

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

60

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00532 CERTIFICATE OF DEATH 00522									
1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>					c. LENGTH OF STAY IN 1b <u>6 days</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Carroll County General Hospital</u>					e. STREET ADDRESS <u>Rural New Windsor</u>				
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARK ALLEN ANTHONY</u>					4. DATE OF DEATH Month Day Year <u>Jan. 3 1966</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 28 1965</u>		9. AGE (in years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <u>6</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Carroll Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Donald F. Anthony Sr.</u>					14. MOTHER'S MAIDEN NAME <u>Barbara Ann Long</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>					16. SOCIAL SECURITY NO.				
17. INFORMANT <u>Mr. Donald Anthony Sr. Same as # 2</u>					Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, biliary pneumonia</u> 7511 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Meningococci</u> DUE TO (c) <u>Cleft Palate</u>									INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>12/28</u> , 19 <u>65</u> , to <u>1/3</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>1/2/66</u> 19 <u>66</u> , and that death occurred at <u>6:45 PM</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>M.E. Robertson</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/3/66</u>		
22c. PHYSICIAN'S NAME (Type) <u>M.E. Robertson</u>					22d. ADDRESS <u>New Windsor, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>Jan. 4 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Linganore Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Unionville, Md.</u>		
24. FUNERAL DIRECTOR <u>C.M. Waltz</u>					25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		
24. ADDRESS <u>Box 241 Sykesville, Md.</u>					DATE <u>JAN 5 1966</u>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VR A15 (4)  
ISM 7/61

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00533					00523				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)				
a. COUNTY		Carroll			a. STATE		Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Rural Mt. Airy			b. COUNTY		Carroll		
c. LENGTH OF STAY IN 1b		18 Months			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Rural Mt. Airy		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		R.F.D. # 2			d. STREET ADDRESS		R.F.D. # 2		
e. IS RESIDENCE ON A FARM?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
First Middle Last					Month Day Year				
Roland E. Babylon					Jan. 5 1966				
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Oct. 30 1904		67 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Carpenter		Building		Carroll Co. Md.		U.S.A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
Joseph Babylon				Florence L. Phillips					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT			
No				219-05-7976		Mrs Mary C. Babylon Same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:								1964	
IMMEDIATE CAUSE (a) Cardiac fibrillation									
4331 DUE TO									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								(b) Cardiac failure with massive cerebral embolism	
								1-5-66	
DUE TO									
(c) Embolism to both femoral arteries									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED?	
								YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year				20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
Hour a.m. p.m. 19				While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
21. I certify that (I) (this hospital) attended the deceased from Jan. 5, 1966, to Jan. 5, 1966, that (I) (we) last saw the deceased alive on Jan. 5, 1966, and that death occurred at 11:45 PM, from the causes and on the date stated above.									
22a. SIGNATURE				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type)			
Howard E. Hall				Jan. 7, 1966		Howard E. Hall, M.D.			
22d. ADDRESS				22e. REC'D BY REGISTRAR					
Sykesville, Maryland				JAN 10 1966					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
Burial		Jan. 8 1966		Bethesda Cemetery		Carroll Co. Md.			
24. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS		25a. REC'D BY REGISTRAR			
C.M. Waltz				Box 241 Sykesville, Md.		JAN 10 1966			

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1954

Order (Continued)

Order follows with number 00530-1-1-55

Order to be made effective

1954

Jan. 2

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00534					00524						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY <b>Carroll</b>					a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 21217 30-4</b>						
c. LENGTH OF RESIDENCE IN 1b <b>1 yr./9 mos/</b>					d. STREET ADDRESS <b>2000 Madison Avenue</b>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Springfield State Hospital</b>					6. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)			First		Middle		Last		4. DATE OF DEATH		
			<b>James</b>		<b>W.</b>		<b>BANKS</b>		Month <b>January</b> Day <b>31</b> , Year <b>19 66</b>		
5. SEX <b>male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-12-1895</b>		9. AGE (in years last birthday) <b>70</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Unkn.</b>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <b>Burrell Banks - dec.</b>						14. MOTHER'S MAIDEN NAME <b>Mary Banks - dec.</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Unkn.</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Springfield State Hospital Records</b>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Pulmonary tuberculosis, moderately advanced, inactive 0022</b> <b>Acute brain syndrome associated with alcohol intoxication.</b>										INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b>  <b>Years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <b>3-3-64</b> , 19__, to <b>1-31-66</b> , 19__, that (I) (we) last saw the deceased alive on <b>1-31-66</b> 19__, and that death occurred at <b>10</b> <b>noon</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Frances Reid Nabors</b>						M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>1/31/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Frances Reid Nabors, M.D.</b>						22d. ADDRESS <b>Springfield State Hospital Sykesville, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>2-2-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Andrew's School</b>			23d. LOCATION (City, town or county) (State) <b>Fel. 2-19 66</b>				
24. FUNERAL DIRECTOR <b>Newell</b>				ADDRESS <b>Potomac, Md.</b>		25a. REC'D BY REGISTRAR <b>FEB 4 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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00535

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00525

1. PLACE OF DEATH a. COUNTY <u>CARROLL COUNTY</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER, MD.</u> c. LENGTH OF STAY IN 1b <u>2 YEARS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>CARROLL COUNTY GEN. HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL RT #6 WESTMINSTER MD-1</u> d. STREET ADDRESS <u>DEER PARK ROAD</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>JACOB</u> First <u>BOLLINGER</u> Middle <u>DEER</u> Last		4. DATE OF DEATH <u>JANUARY 9TH</u> 19 <u>66</u> Month Day Year		5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>4/11/1884</u>		9. AGE (in years last birthday) <u>81</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>				11. BIRTHPLACE (County & State, or foreign country) <u>OHIO</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>WILLIAM BOLLINGER</u>						14. MOTHER'S MAIDEN NAME <u>LYDIA STUMP</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>288-32-5296</u>				17. INFORMANT <u>RT. 2 FINKSBURG, MD.</u> Address <u>DAUGHTER MARY NIGHTENGALE</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>490X</u> (b) <u>Pneumonia, Right lobar</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>1 week</u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH - (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>6/4</u> , 19 <u>58</u> , to <u>1/9</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>1/9</u> , 19 <u>66</u> , and that death occurred at <u>5:59 P</u> M, from the causes and on the date stated above.															
22a. SIGNATURE <u>Julius Chepko</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22b. DATE SIGNED <u>1/9/66</u>					
22c. PHYSICIAN'S NAME (Type) <u>JULIUS CHEPKO</u>										22d. ADDRESS <u>85 1/2 E. GREEN ST. WESTMINSTER MD</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>1/13/66</u>				23c. NAME OF CEMETERY OR CREMATORY <u>FISH CEMETERY</u>				23d. LOCATION (City, town or county) (State) <u>NEW ROCHESTER OHIO</u>			
24. FUNERAL DIRECTOR <u>James G. Saffell</u>										25a. REC'D BY REGISTRAR <u>12</u> DATE <u>12 1966</u>				25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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<b>1. PLACE OF DEATH</b> a. COUNTY <u>Carroll</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Woodbine</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Golden Age Guest House</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HOWARD</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ELLICOTT CITY 13-2</u> d. STREET ADDRESS <u>44 COLUMBIA ROAD</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) <u>Beatha</u> First <u>Boone</u> Middle Last		<b>4. DATE OF DEATH</b> <u>Jan 30</u> Month <u>1966</u> Year		<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Nov. 7, 1875</u>		<b>9. AGE</b> (In years last birthday) <u>91</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS.: Hours <u>  </u> Min. <u>  </u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>NONE</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>HOWARD Co., Md.</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b>					
<b>13. FATHER'S NAME</b> <u>JOHN SMALL WOOD</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>REBECCA HIRSLEY</u>									
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <u>NONE</u>		<b>17. INFORMANT</b> <u>LEWIS W. BOONE, ELLICOTT CITY MD</u> Address									
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Ch. Myocarditis</u> (a), stating the underlying cause last. DUE TO (c) <u>Int. Coronary Sclerosis</u>												INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>8</u> <u>8</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)		<b>21. I certify that (I) (this hospital)</b> attended the deceased from <u>Dec 11</u> ....., 19 <u>64</u> to <u>Jan 30</u> , 19....., that (I) (we) last saw the deceased alive on <u>Jan 30</u> .....19 <u>66</u> , and that death occurred at <u>3:30</u> M, from the causes and on the date stated above.					
<b>22a. SIGNATURE</b> <u>M N Martin</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		<b>22b. DATE SIGNED</b>							
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>M N MARTIN</u>						<b>22d. ADDRESS</b>									
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>				<b>23b. DATE THEREOF</b> <u>2-3-66</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>ST JOHNS</u>				<b>23d. LOCATION</b> (City, town or county) (State) <u>ELLICOTT CITY MD</u>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>F.P. HIGINBOTHAM, ELLICOTT CITY MD</u>						ADDRESS		<b>25a. REC'D BY REGISTRAR</b> <u>FEB 7 1966</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>					

00230

00230

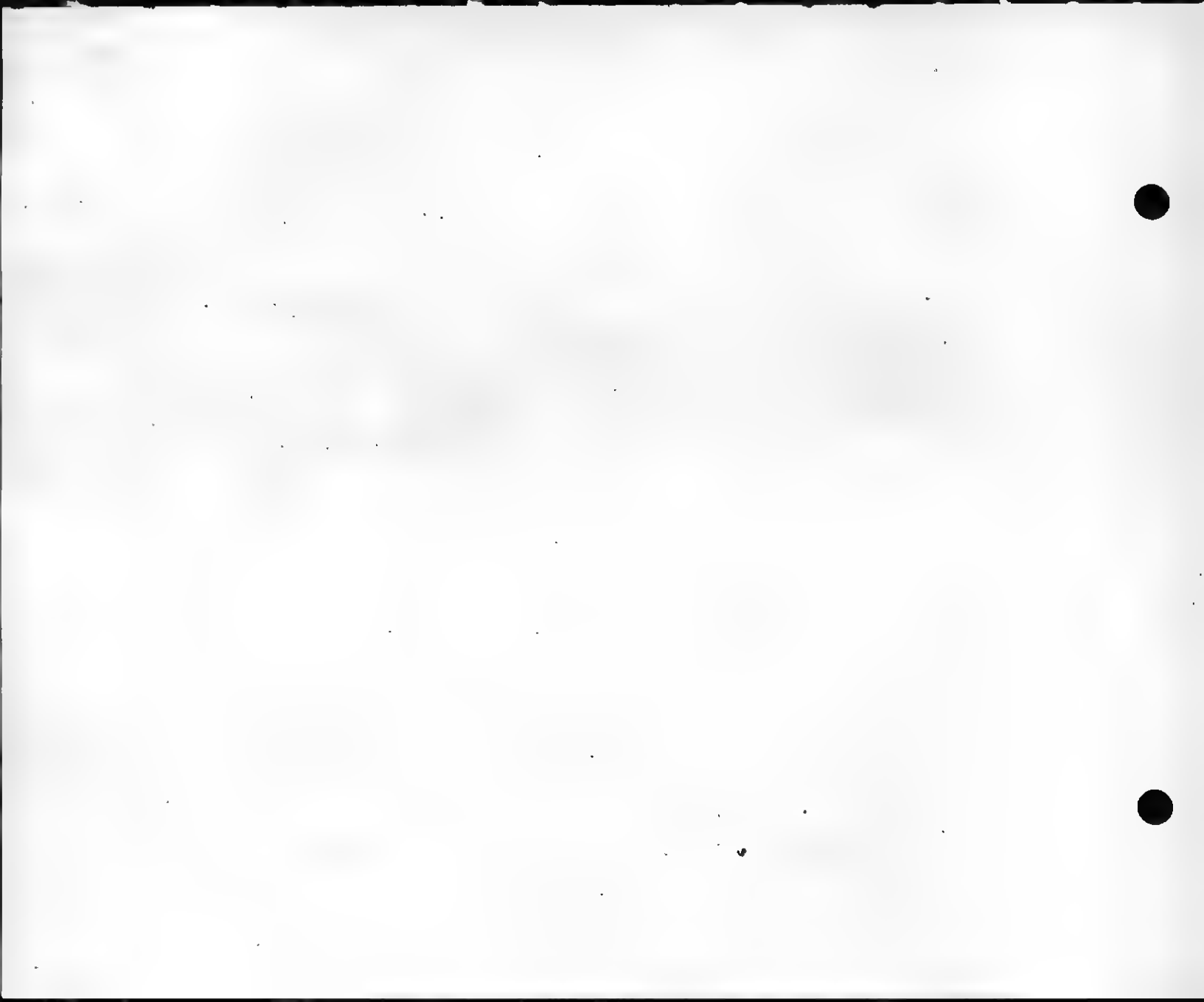
THE UNIVERSITY OF CHICAGO



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <div> <p>1</p> <p>00537</p> </div> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>CERTIFICATE OF DEATH</p> </div> <div> <p>00527</p> </div> </div>											
1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>				c. LENGTH OF STAY IN 1b <u>20 HOURS</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER RURAL</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>CARRILL CO GENERAL HOSPITAL</u>						d. STREET ADDRESS <u>UNIONTOWN ROAD</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CARRIE</u> Middle <u>ZEMGRA</u> Last <u>BUFFINGTON</u>						4. DATE OF DEATH Month <u>1</u> Day <u>6</u> Year <u>1966</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT 25 - 1905</u>		9. AGE (in years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE KEEPER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U A</u>			
13. FATHER'S NAME <u>CHARLES C CRABBS</u>						14. MOTHER'S MAIDEN NAME <u>AMELIA COPENHAVER</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>EMORY BUFFINGTON</u>		Address <u>R5 MD WESTMINSTER</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR ACCIDENT</u> <u>4221</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR</u> DUE TO (c) <u>DISEASE.</u> INTERVAL BETWEEN ONSET AND DEATH <u>24 HOURS</u> YEARS <u>  </u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>RHEUMATIC HEART DISEASE</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1/5</u> , 19 <u>66</u> , to <u>1/6</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>1/6</u> 19 <u>66</u> , and that death occurred at <u>4:35</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Vincent J. Fusco Jr</u>						M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/6/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>DR VINCENT J FUSCO</u>						22d. ADDRESS <u>WESTMINSTER MD</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>1/9/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>LUTHERAN</u>		23d. LOCATION (City, town or county) (State) <u>UNIONTOWN MD</u>			
24. FUNERAL DIRECTOR <u>SS Hartzler &amp; Sons New Windsor, Md</u>						25a. REC'D BY REGISTRAR <u>  </u> DATE <u>JAN 10 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. Juge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00538

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00528

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Westminster</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Carroll County Hospital</b>		d. STREET ADDRESS <b>59 Admiral Blvd.</b>	
3. NAME OF DECEASED (Type or print) First <b>Lillian</b> Middle <b>B.</b> Last <b>Carr</b>		4. DATE OF DEATH Month <b>1</b> Day <b>14</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 28, 1905</b>
9. AGE (in years last birthday) <b>60</b> yrs.		IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George R. Sheesley</b>		14. MOTHER'S MAIDEN NAME <b>Rose M. Mc Gaughey</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Grant H. Sheesley</b>		Address <b>59 Admiral Blvd.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BLEEDING ESOPHAGEAL VARICES</b> DUE TO (b) <b>POST NECROTIC CIRRHOSIS</b> DUE TO (c) <b>ARTERIOSCLEROTIC HEART DISEASE</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b> <b>YEARS</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1/12, 1966</b> to <b>1/14, 1966</b> , that (I) (we) last saw the deceased alive on <b>1/14, 1966</b> , and that death occurred at <b>2:05</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Vincent J. Froese Jr.</b> M.D.		22b. DATE SIGNED <b>1/14/66</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/17/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Meadow Ridge</b>		23d. LOCATION (City, town or county) (State) <b>Dorsey, Md.</b>	
24. FUNERAL DIRECTOR <b>Ullrich Funeral Home Dundalk, Md.</b>		25a. REC'D BY REGISTRAR <b>DATE JAN 18 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>John Charles Judge</b>			

1944





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

<div style="display: flex; justify-content: space-between;"> <div>00539</div> <div> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div> <div>00529</div> </div>											
1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(Rural) Sykesville</b> c. LENGTH OF STAY IN 1b <b>1 yr Om 3 da</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> d. STREET ADDRESS <b>2103 Belvedere Boulevard</b> e. IS RESIDENCE ON A FARM? <b>YES</b> NO <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Truman</b> Middle <b>Ross</b> Last <b>Cissel</b>				4. DATE OF DEATH Month <b>1</b> Day <b>29</b> Year <b>1966</b>							
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-3-1880</b>		9. AGE (In years last birthday) <b>85</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant - Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>--Self employed</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Wilbur Cissel</b>						14. MOTHER'S MAIDEN NAME <b>Helen F. Cissel CLARA E. BROWN</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>unknown --</b>				16. SOCIAL SECURITY NO. <b>217-32-0979</b>		17. INFORMANT <b>Mrs. Dorothy C. Lennick, S.S. Md. Hospital Records 2103 Belvedere Blvd.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure and kidney failure.</b> 446x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Arteriosclerotic heart disease.</b> DUE TO (c) <b>Nephrosclerosis.</b>										INTERVAL BETWEEN ONSET AND DEATH <b>wks. or mos.</b> <b>years</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Brain Syndrome associated with cerebral arterio-sclerosis with psychotic reaction</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>---</b>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. --- p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>---</b>		20f. (City or town) (County) (State)			
21. I certify that (X) (this hospital) attended the deceased from <b>1-26</b> , 19 <b>65</b> , to <b>1-29</b> , 19 <b>66</b> , that (X) (we) last saw the deceased alive on <b>1-29</b> , 19 <b>66</b> , and that death occurred at <b>6:15 A.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Frances Reid Nabors</b>						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>Jan. 29, 1966</b>			
22c. PHYSICIAN'S NAME (Type) <b>Frances Reid Nabors</b>						22d. ADDRESS <b>Springfield State Hospital</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-4-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Marks Epis. Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>R Fairland, Maryland</b>					
24. FUNERAL DIRECTOR <b>Warner E. Pumphrey, Ind.</b>						25a. REC'D BY REGISTRAR <b>8434 Georgia Avenue Silver Spring, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



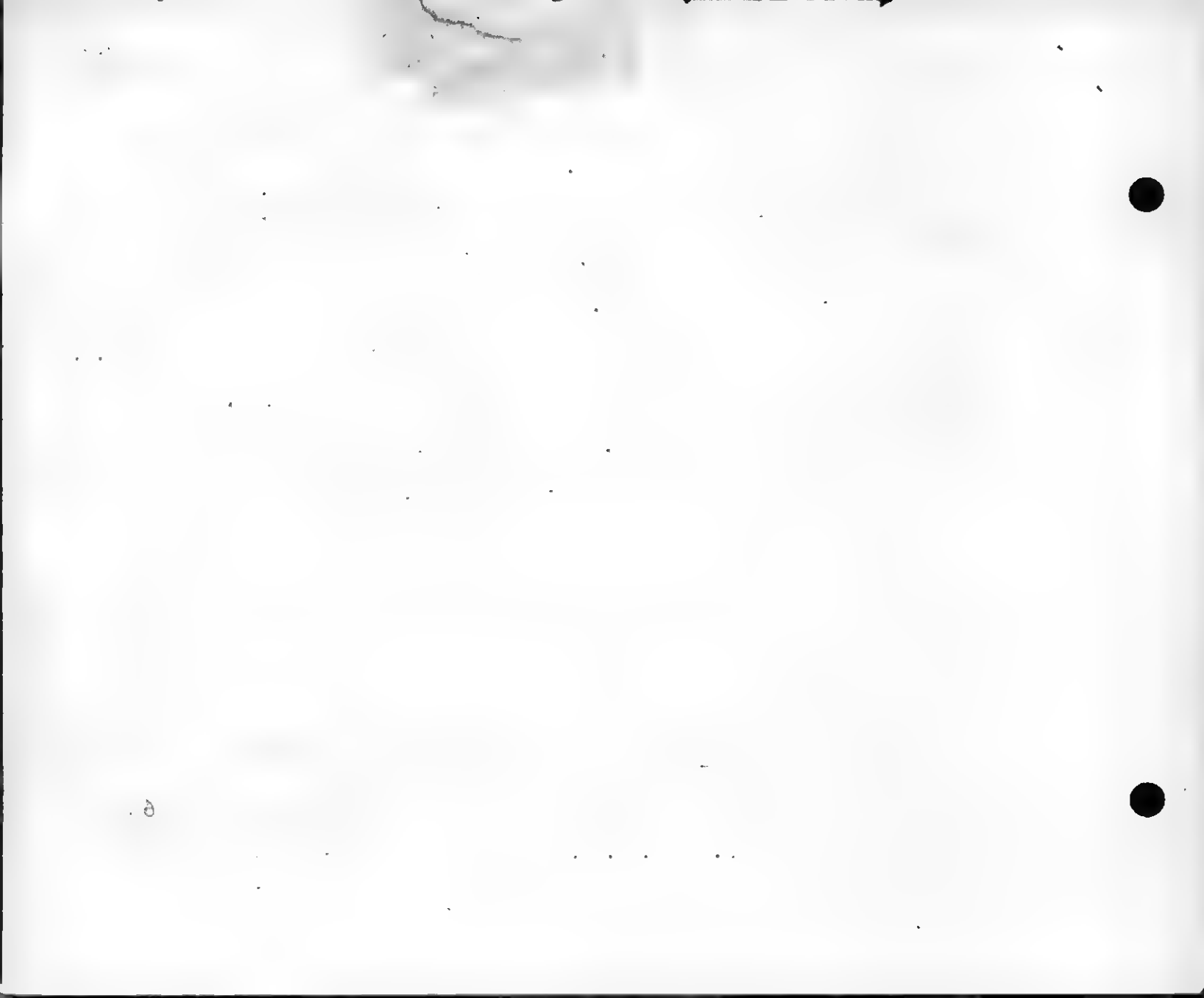
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
00540 CERTIFICATE OF DEATH 00530														
1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> c. LENGTH OF STAY IN 1b <b>15 dys.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Springfield State Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>903 Lake Dr apt 8c</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) <b>ELI</b>			First <b>ELI</b>			Middle <b>COHEN</b>			Last <b>COHEN</b>			4. DATE OF DEATH Month <b>JANUARY</b> Day <b>25</b> Year <b>1966</b>		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-17-1894</b>		9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>		IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>Joseph Cohen</b>						14. MOTHER'S MAIDEN NAME <b>Isela (last name unk.)</b>								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>212-05-9303</b>		17. INFORMANT Address <b>Records, Springfield State Hospital</b>								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral bronchopneumonia, massive</b> <b>441X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)						
21. I certify that (I) (this hospital) attended the deceased from <b>1-10-66</b> to <b>1-25-66</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>1-25-66</b> , 19 <b>66</b> , and that death occurred at <b>8:00 PM</b> , from the causes and on the date stated above.														
22a. SIGNATURE <b>Octavio A. Ruiz</b>						M.O. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>1-26-66</b>						
22c. PHYSICIAN'S NAME (Type) <b>Octavio A. Ruiz, M. D.</b>						22d. ADDRESS <b>Springfield State Hospital Sykesville, Maryland</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>1/27/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenwood</b>				23d. LOCATION (City, town or county) (State) <b>Baltimore, Md</b>						
24. FUNERAL DIRECTOR <b>Bob Lennor &amp; Bros Inc</b>						25a. REC'D BY REGISTRAR <b>6610 Regs</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>						
DATE <b>FEB 1 1966</b>														



TO HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

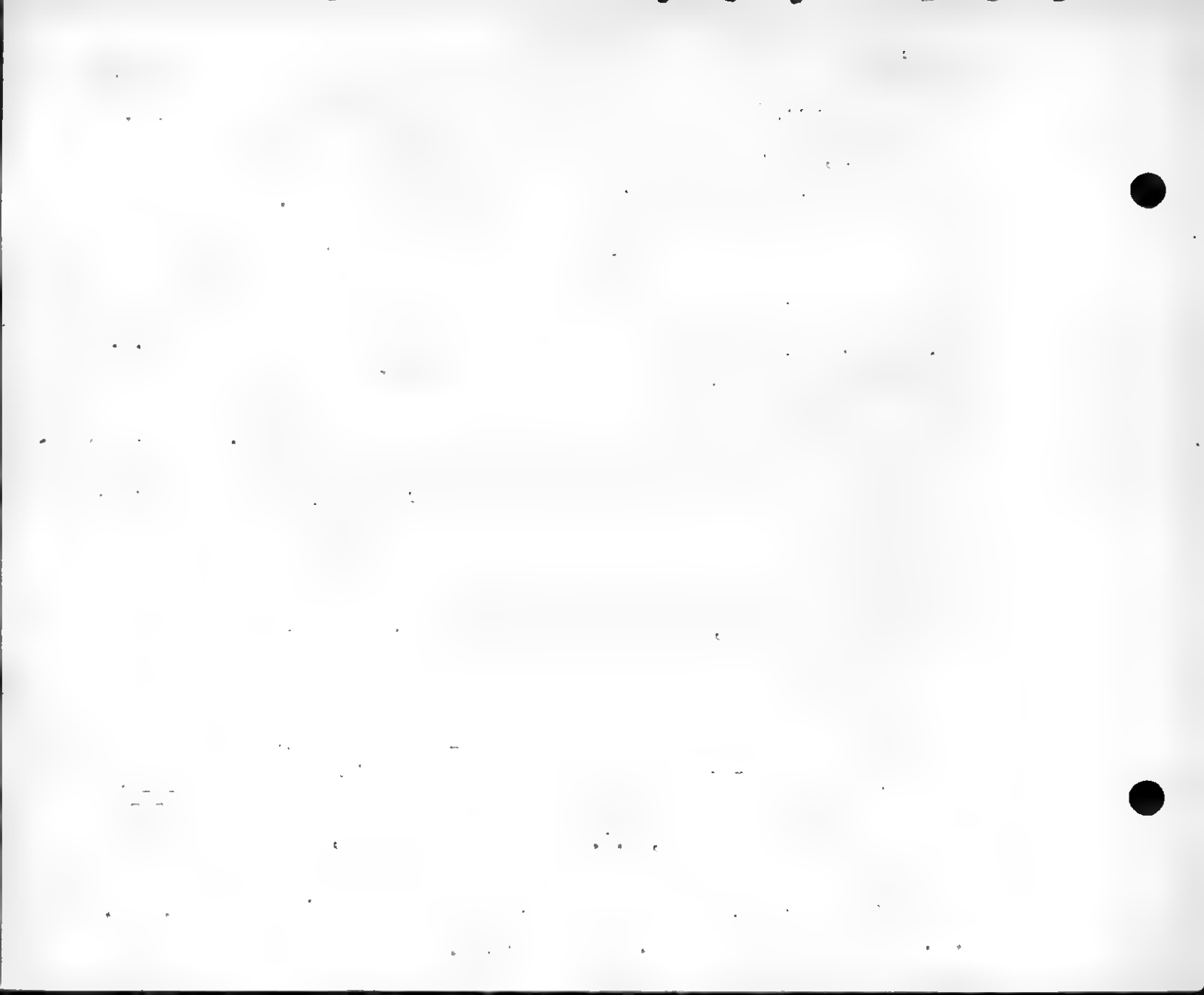
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00541

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00531

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sykesville, (Rural)</b> c. LENGTH OF STAY in 1b <b>23yr 6mo 16</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Springfield State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>1208 Greystone Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Agnes G. Coogan</b>		4. DATE OF DEATH <b>1 1 19 66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-22-77</b>
9. AGE (in years) <b>88</b> (first birthday) <b>88</b>		IF UNDER 1 YEAR: Months <b>8</b> Days <b>1</b> Hours <b>19</b> Min. <b>66</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Business AT HOME</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>New York</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JAMES FINNERTY</b>		14. MOTHER'S MAIDEN NAME <b>ELLEN LYONS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>(If yes give war or dates of service)</b>	
17. INFORMANT <b>Records Springfield Hosp. Sykesville, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardio Vascular Disease</b> 42+1 DUE TO (b) <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> DUE TO (c) <b>Affective reaction, manic depressive reaction, depressed type</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Affective reaction, manic depressive reaction, depressed type</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>19 66</b> Hour a.m. <b>3:45</b> p.m. <b>AM</b>		20d. INJURY OCCURRED <b>While at work</b> <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Sykesville, Maryland</b>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>6-16-42</b> , 19 <b>66</b> , to <b>1-1-66</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>1-1-66</b> , 19 <b>66</b> , and that death occurred at <b>3:45 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Dr. Antonius Glahn, M.D.</b>		22b. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> <b>1-1-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Antonius Glahn, M.D.</b>		22d. ADDRESS <b>Sykesville, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>1/4/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>NEW CATHEDRAL</b>		23d. LOCATION (City, town or county) (State) <b>BALTIMORE, Md.</b>	
24. FUNERAL DIRECTOR <b>H.W. MEARS &amp; SON 805 N. CALVERT ST.</b>		25. REC'D BY REGISTRAR <b>Charles Judge</b>	
25a. ADDRESS <b>H.W. MEARS &amp; SON 805 N. CALVERT ST.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

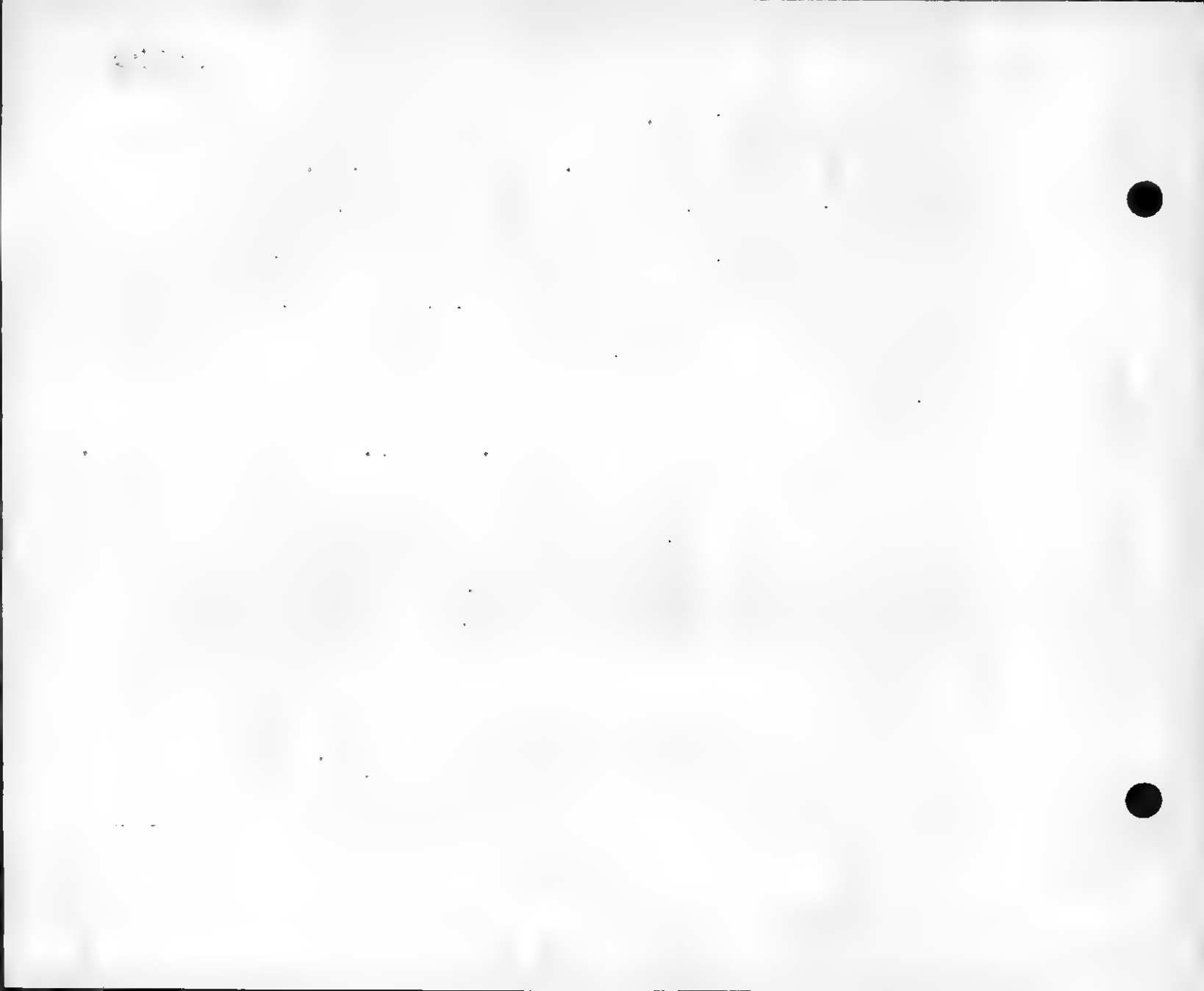
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00542

## CERTIFICATE OF DEATH

00532

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>Sykesville,</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>5 1/2 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brookville, Md.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Springfield State Hospital</b>			d. STREET ADDRESS <b>Route #1 Box 85A</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Lavinia</b> Middle <b>Duchemin</b> Last <b>Currier</b>			4. DATE OF DEATH Month <b>January</b> Day <b>14</b> Year <b>1966</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-25-1865</b>	9. AGE (In years last birthday) <b>100 yrs.</b>	IF UNDER 1 YEAR Months <b>10</b> Days <b>14</b> Hours <b>14</b> Min. <b>14</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Canada</b>	
13. FATHER'S NAME <b>Duchemin</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT <b>Mrs. Buelah F. Sargent Brookville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Conjunctive Heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Generalized Arterio-sclerosis</b>					INTERVAL BETWEEN ONSET AND DEATH <b>Weeks</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>JUNE</b> , 19 <b>66</b> , to <b>1-14</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>1-14</b> , 19 <b>66</b> , and that death occurred at <b>4:40</b> M, from the causes and on the date stated above.					
22a. SIGNATURE <b>Suha Ozgun</b>			22b. DATE SIGNED <b>1-14-66</b>		
22c. PHYSICIAN'S NAME (Type) <b>Suha Ozgun</b>			22d. ADDRESS <b>SYKESVILLE, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-17-66</b>		23c. NAME OF CEMETERY OR OREMATORY <b>Oak Grove</b>	
23d. LOCATION (City, town or county) <b>Shirwood Heights Md.</b>		23e. (State) <b>Md.</b>		23f. (Country) <b>USA</b>	
24. FUNERAL DIRECTOR <b>Arthur A. Haight Sykesville, Md.</b>			25a. REC'D BY REGISTRAR <b>Charles Judge</b>		
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			25c. DATE <b>JAN 18 1966</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00543						00533					
1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Taneytown</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>48 Middle Street</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Taneytown</b> d. STREET ADDRESS <b>48 Middle Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>Raymond</b> Middle <b>Fleagle</b> Last <b>Davidson</b>						4. DATE OF DEATH Month <b>January</b> Day <b>21</b> Year <b>1966</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 4, 1890</b>		9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months <b>75</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Route Salesman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Bakery</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Carroll Co., Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Charles Davidson</b>						14. MOTHER'S MAIDEN NAME <b>Sarah Fleagle</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <b>215-32-1265</b>		17. INFORMANT <b>RFD Westminster, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> DUE TO (b) <b>Coronary Heart Disease</b> Conditions, if any, which gave rise to immediate cause (c) <b>Generalized Arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Obesity</b> INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b> <b>4 yrs</b> <b>8 yrs</b>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>1957</b> to <b>1/21</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>12/12</b> , 19 <b>63</b> , and that death occurred at <b>11P</b> M, from the causes and on the date stated above.											
22a. SIGNATURE <b>E. Ambler Thompson</b> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <b>1/22/66</b>		
22c. PHYSICIAN'S NAME (Type) <b>E. Ambler Thompson</b>						22d. ADDRESS <b>Taneytown, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/24/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lutheran Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>Taneytown, Maryland</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>C.O. Fuss &amp; Son</b> <b>John M. Fuss</b> Address <b>Taneytown, Md.</b>						25a. REC'D BY REGISTRAR <b>JAN 25 1966</b>		25b. REGISTRAR'S SIGNATURE <b>John M. Judge</b>			



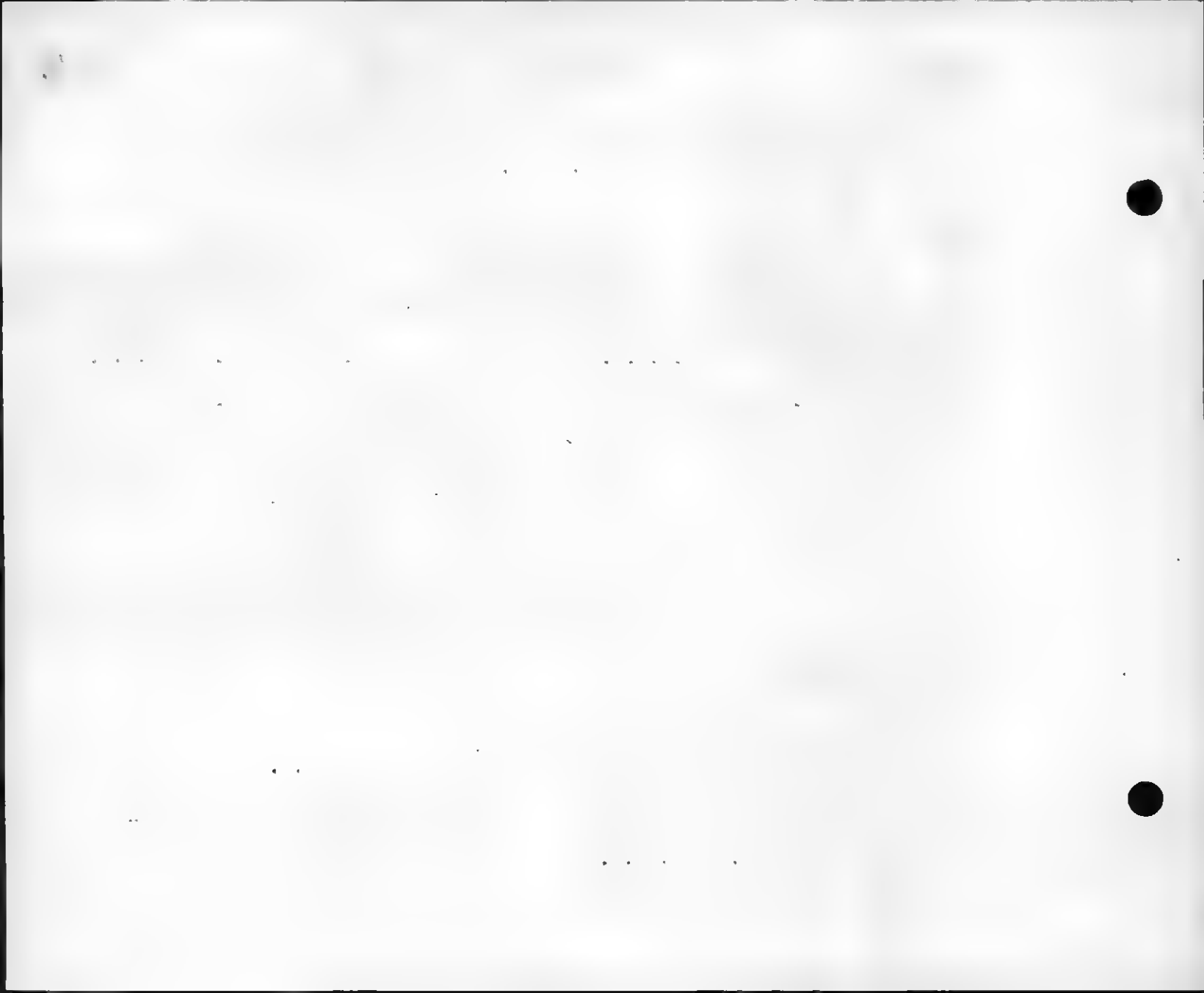
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VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
00544 100534											
1. PLACE OF DEATH a. COUNTY Carroll						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sykesville						b. COUNTY Washington					
c. LENGTH OF STAY IN 1b 6 mos. 1 dy						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springfield State Hospital						d. STREET ADDRESS Route #1					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First ERIE			Middle HALET			Last DE HART			4. DATE OF DEATH Month January		
Day 4			Year 19 66								
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-25-90		9. AGE (in years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad Engineer				10b. KIND OF BUSINESS OR INDUSTRY W.M.R.R.				11. BIRTHPLACE (County & State, or foreign country) Virginia, Patrick Co.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME H.H.H.H.H S. Rufus Dehart						14. MOTHER'S MAIDEN NAME H.H.H.H.H Lausey A. Bowers					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 70-10-6782		17. INFORMANT Address Records, Springfield State Hospital					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4 2 2 1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 7-3-65, 19 to 1-4-66, 19, that (I) (we) last saw the deceased alive on 1-4-66, 19, and that death occurred at 5:15 p.m. from the causes and on the date stated above.											
22a. SIGNATURE Octavio A. Ruiz						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED 1-5-66		
22c. PHYSICIAN'S NAME (Type) Octavio A. Ruiz, M.D.						22d. ADDRESS Springfield State Hospital Sykesville, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1-7-66		23c. NAME OF CEMETERY OR CREMATORY REST HAUVEN CEMETERY				23d. LOCATION (City, town or county) (State) HAGERSTOWN, MARYLAND			
24. FUNERAL DIRECTOR Charles F. Jones						ADDRESS REST HAUVEN FUNERAL CHAPEL, INC. HAGERSTOWN, MD.		25a. REC'D BY REGISTRAR JAN 6 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12

BT

MARYLAND STATE DEPARTMENT OF HEALTH

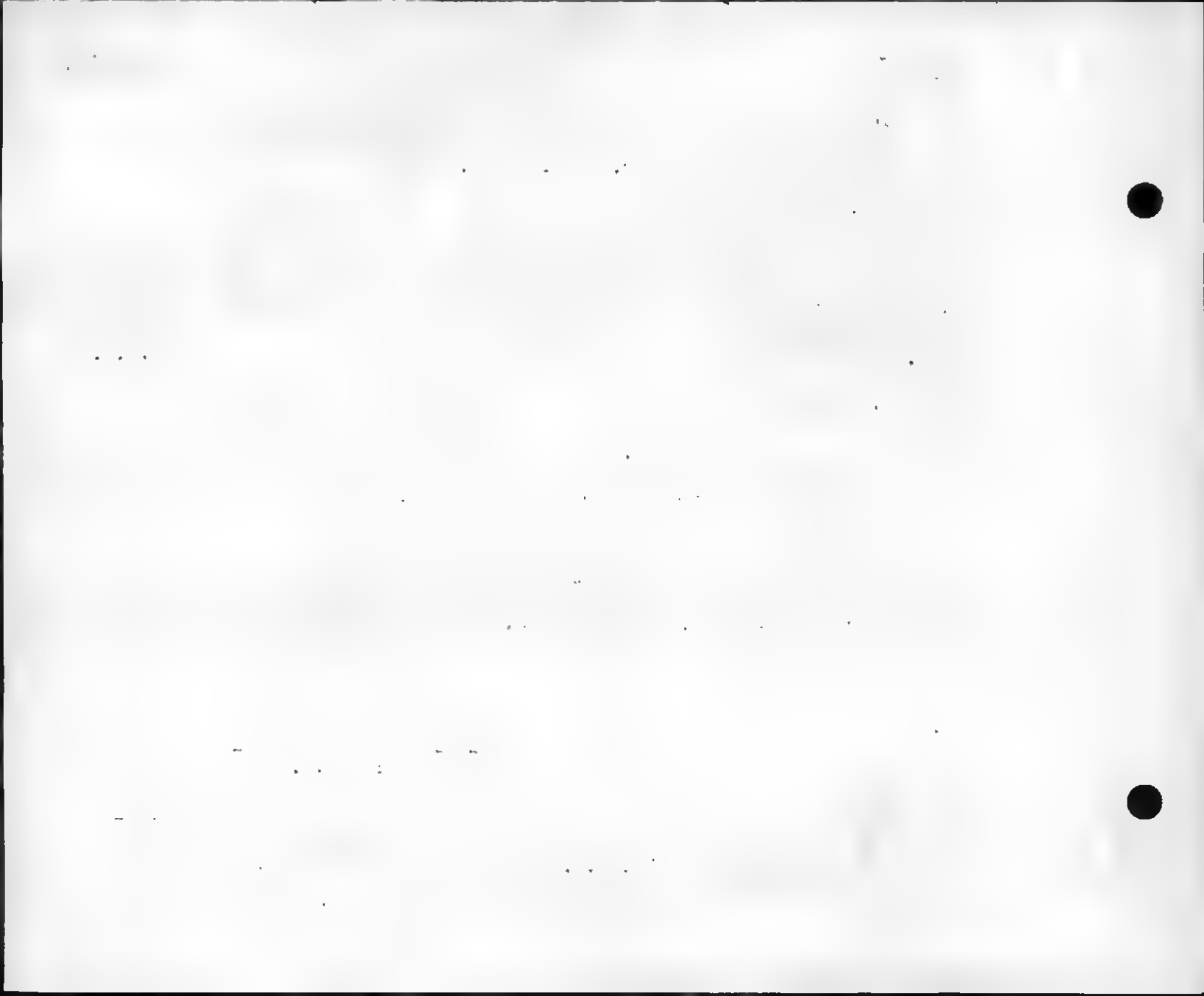
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00545

00535

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> c. LENGTH OF STAY IN 1b <b>9 yr. 3 mo. 2</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>dys. Bethesda</b> d. STREET ADDRESS <b>4812 North Lane</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>WINONA MARGARET EBERHART</b>		4. DATE OF DEATH Month Day Year <b>January 18 19 66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-17-03</b>
9. AGE (In years last birthday) <b>62</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unk.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Indiana</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>David C. Eberhart</b>		14. MOTHER'S MAIDEN NAME <b>Jeanette Fertich</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unk.</b>	
17. INFORMANT <b>Records, Springfield State Hospital</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> DUE TO (b) <b>Coronary occlusion</b> DUE TO (c) <b>Arteriosclerotic heart disease</b> CONDITIONS, If any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Schizophrenic reaction, paranoid type.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10-15-56</b> to <b>1-18-66</b> , 19____, that (I) (we) last saw the deceased alive on <b>1-18-66</b> , 19____, and that death occurred at <b>9:45 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Dr. Antonius Glahn</b>		22b. DATE SIGNED <b>1-18-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Antonius Glahn, M.D.</b>		22d. ADDRESS <b>Springfield State Hospital Sykesville, Maryland 21784</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>1-24-66</b>		23b. DATE THEREOF <b>1-24-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>U. S. Med. Med. School</b>		23d. LOCATION (City, town or county) (State) <b>BALTIMORE Md.</b>	
24. FUNERAL DIRECTOR <b>Newell Funeral Home</b>		25a. REC'D BY REGISTRAR <b>1-25-66</b>	
ADDRESS <b>110 N. Main St.</b>		25b. REGISTRAR'S SIGNATURE <b>John</b>	

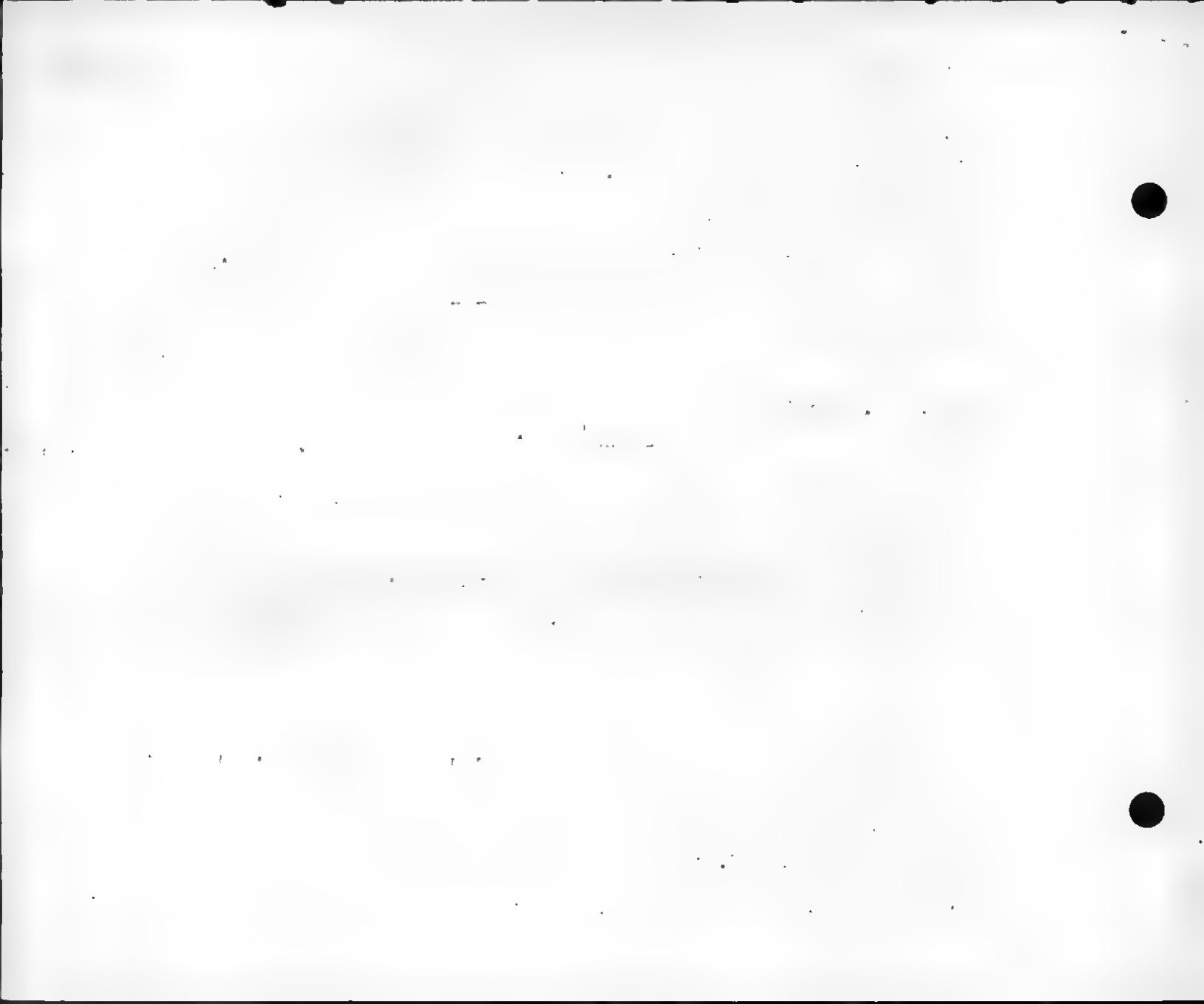


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00546 CERTIFICATE OF DEATH 00536

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural Sykesville</b>		c. LENGTH OF STAY IN 1b <b>2mo. 27 days</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>30 - 4</b>		d. STREET ADDRESS <b>4616 Manordene Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Florence Elizabeth Ellis</b>		First		Middle		Last		4. DATE OF DEATH Month <b>Jan.</b>		Day <b>2</b>		Year <b>1966</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-3- 87</b>		9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months <b>9</b>		IF UNDER 24 HRS. Days <b>3</b>		Hours <b>10</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		13. FATHER'S NAME <b>John J. Corbitt</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth McGeeney</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-89-4052</b>			
17. INFORMANT <b>Husband's</b>		Address <b>Springfield Hsps. Records Sykesville, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cardiac Failure</b> DUE TO (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (c) <b>Chronic Brain Syndrome Associated with Cerebral Arteriosclerosis with behavioral reaction</b>		INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>Oct. 6, 1965</b> , to <b>Jan. 2, 1966</b> , that (I) (we) last saw the deceased alive on <b>JAN 2 1966</b> , and that death occurred at <b>2:30 A.M.</b> from the causes and on the date stated above.		22a. SIGNATURE <b>Robert N. Deeb</b>		22b. DATE SIGNED <b>JAN 2 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert N. Deeb</b>		22d. ADDRESS		22e. ATTENDING PHYS. <input type="checkbox"/> M.D.		22f. MED. DIRECTOR <input type="checkbox"/>		22g. STAFF PHYS. <input checked="" type="checkbox"/>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-5-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>NEW CATHEDRAL</b>		23d. LOCATION (City, town or county) (State) <b>Balto MD</b>		24. FUNERAL DIRECTOR <b>Chas. F. Evanson</b>		25a. REC'D BY REGISTRAR <b>JAN 4 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>					



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the page from the papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00547		00537	
1. PLACE OF DEATH a. COUNTY <u>Carroll</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>	
c. LENGTH OF STAY in 1b <u>1.5 years</u>		d. STREET ADDRESS <u>Water Tank Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Water Tank Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Sarah Matilda Emendius</u>		4. DATE OF DEATH Month Day Year <u>January 18 1966</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 11, 1877</u>	
9. AGE (In years last birthday) <u>88 yrs.</u>		10. UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Chancery, Ind. Penna</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Caldwell</u>		14. MOTHER'S MAIDEN NAME <u>Phoebe Ann Flynn</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. Helen Smith</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 443 X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c)	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS A POSTMORTEM PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this physician) attended the deceased from <u>August 24, 1964</u> to <u>January 18, 1966</u> , that (I) (we) last saw the deceased alive on <u>January 17, 1966</u> , and that death occurred at <u>6:38 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Joseph E. Bush M.D.</u>		22b. DATE SIGNED <u>January 18, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>Joseph E. Bush M.D.</u>		22d. ADDRESS <u>Hampstead Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-22-1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Bethel Methodist Cem</u>		23d. LOCATION (City, town or county) (State) <u>York Co. Penna</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Jacob Hartenstein</u>		24b. ADDRESS <u>New Freedom, Pa.</u>	
25a. REC'D BY REGISTRAR <u>JAN 22 1966</u>		25b. REGISTRAR'S SIGNATURE <u>William J. Judge</u>	



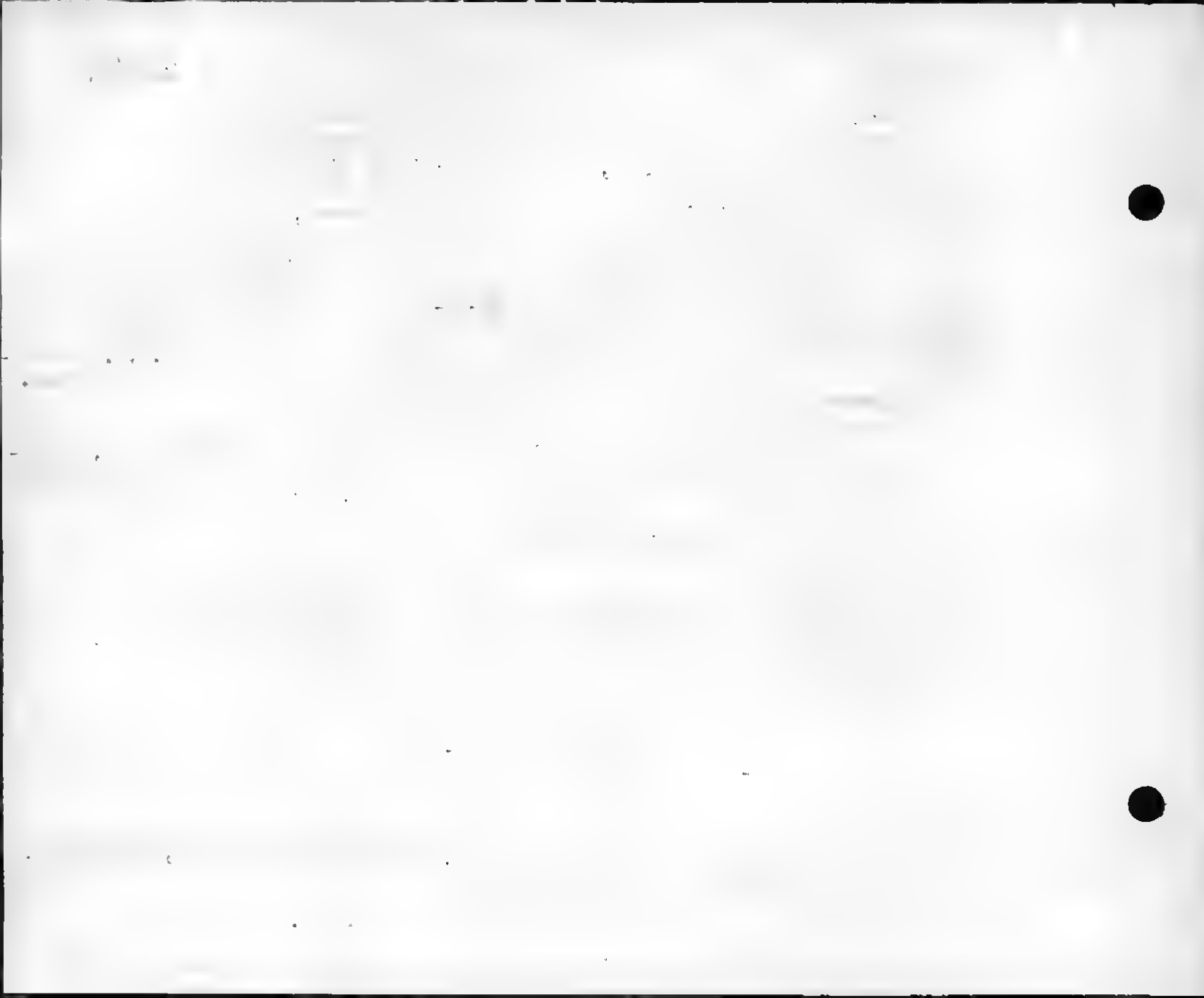


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VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00548 Item #4 Film #G373-2/12/66 CERTIFICATE OF DEATH 00538											
1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> c. LENGTH OF STAY IN b <b>4 mo,</b>						USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore City</b> d. STREET ADDRESS <b>3703 6th Street,</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>ANNA DOMINYAK ENGEL</b>						4. DATE OF DEATH <b>JANUARY 25 1966</b>					
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>02-07-89</b>		9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR: Months <b>25</b> Days <b>19</b> Hours <b>66</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Hungary</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A. natural-ized.</b>			
13. FATHER'S NAME <b>STEVE DOMINYAK</b>						14. MOTHER'S MAIDEN NAME <b>Anna Gajdas</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>						16. SOCIAL SECURITY NO. <b>Records of Springfield State Hospital, Sykesv-</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>Acute pulmonary artery embolism, source unknown</b> <b>420</b> DUE TO <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>years</b>											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <b>19 66</b> Hour e.m. <b>1-2</b> p.m. 20d. INJURY OCCURRED <b>While at work</b> <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <b>1-2</b> (County) <b>66</b> (State) <b>19</b>											
21. I certify that (I) (this hospital) attended the deceased from <b>9-22-65</b> , 19 <b>66</b> to <b>1-2</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>1-2</b> , 19 <b>66</b> , and that death occurred at <b>11:50 PM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Frank M. Sells</b>						22b. DATE SIGNED <b>1/24/66</b>					
22c. PHYSICIAN'S NAME (Type) <b>Frank M. Sells</b>						22d. ADDRESS <b>Springfield State Hospital, Sykesville,</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>1/28/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GARDEN OF FAITH BALTO MD</b>		23d. LOCATION (City, town or county) <b>BALTO MD</b>		23e. REGISTRAR'S SIGNATURE <b>Frank M. Sells</b>			
24. FUNERAL DIRECTOR <b>Frank M. Sells</b>						25. REC'D BY REGISTRAR <b>1/28/66</b>					

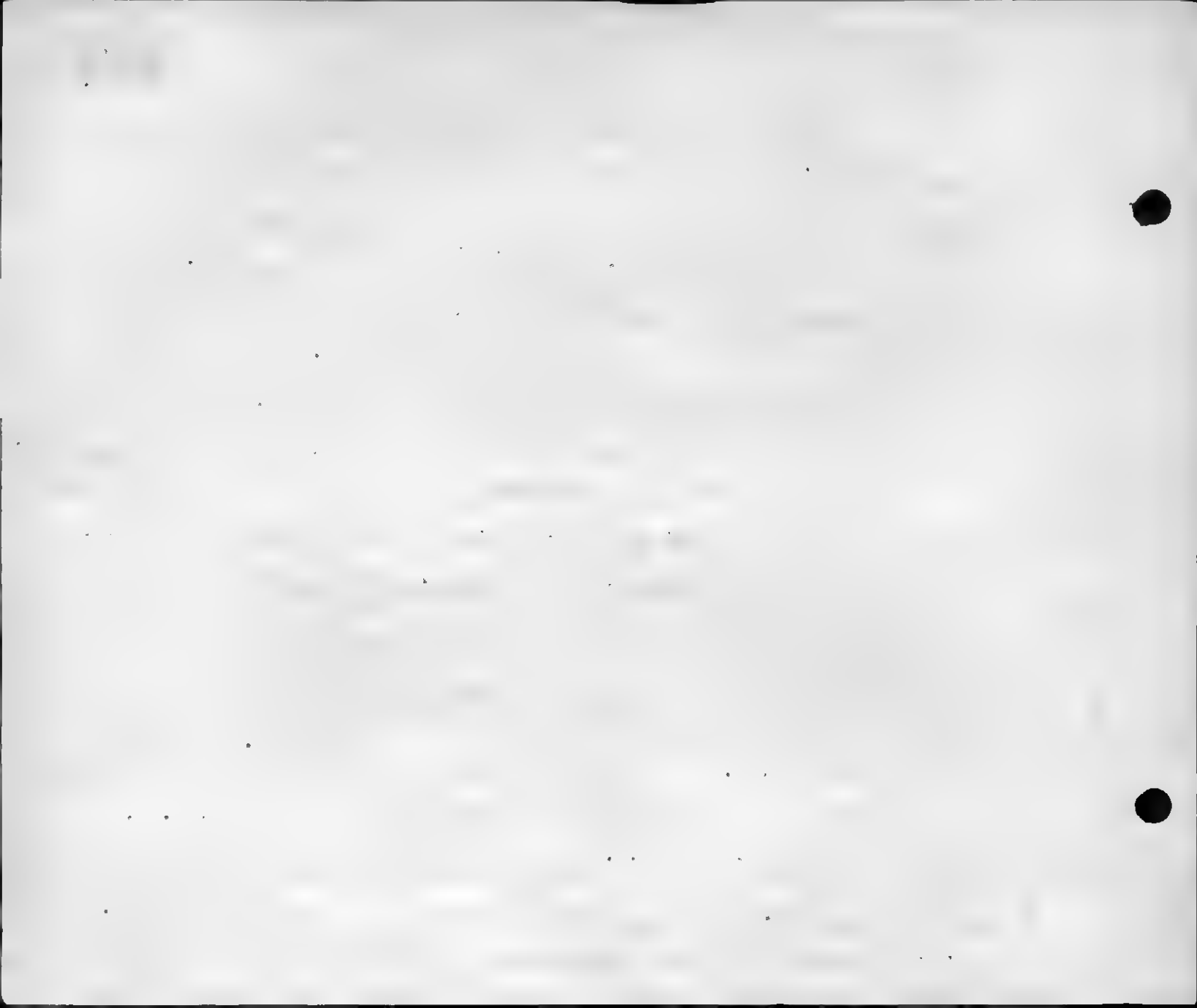


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VR A15 (4)  
20M 5-63

<div>1</div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>CERTIFICATE OF DEATH</div> </div> <div>00549</div> <div>00539</div>												
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Carroll</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Woodbine</u> c. LENGTH OF STAY IN 1b <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Woodbine</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
<b>3. NAME OF DECEASED</b> (Type or print) <u>Charles M. Frederick</u>						<b>4. DATE OF DEATH</b> Month <u>Jan.</u> Day <u>7</u> Year <u>1966</u>						
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Oct. 27 1893</u>		<b>9. AGE</b> (In years last birthday) <u>72</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Plumber</u>						<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Carroll Co. Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>				
<b>13. FATHER'S NAME</b> <u>Thomas E. Frederick</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Fannie I. Mills</u>						
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>						<b>16. SOCIAL SECURITY NO.</b> <u>219-20-1257</u>		<b>17. INFORMANT</b> <u>Mrs. Estella G. Frederick Same as #2</u>				
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Articular fibrillation, cardiac failure</u> (c) <u>Arteriosclerosis generalized, diabetes</u> (a), stating the underlying cause last										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>1964</u> <u>1-7-66</u>		
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I</b>												
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)						<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)						
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u>			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>1964</u> , to <u>Jan. 7</u> , <u>1966</u> , that (I) (we) last saw the deceased alive on <u>Jan. 7</u> , <u>1966</u> , and that death occurred at <u>7:40</u> from the causes and on the date stated above.												
<b>22a. SIGNATURE</b> <u>Howard E. Hall</u>						<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>Jan. 7, 1966</u>				
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Howard E. Hall, M.D.</u>						<b>22d. ADDRESS</b> <u>Sykesville, Maryland</u>						
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>			<b>23b. DATE THEREOF</b> <u>Jan. 10 1966</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Morgan Chapel</u>			<b>23d. LOCATION (City, town or county)</b> <u>Carroll Co. Md.</u>			<b>(State)</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>C.M. Waltz</u>						<b>ADDRESS</b> <u>Box 241 Sykesville, Md.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>JAN 10 1966</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>		

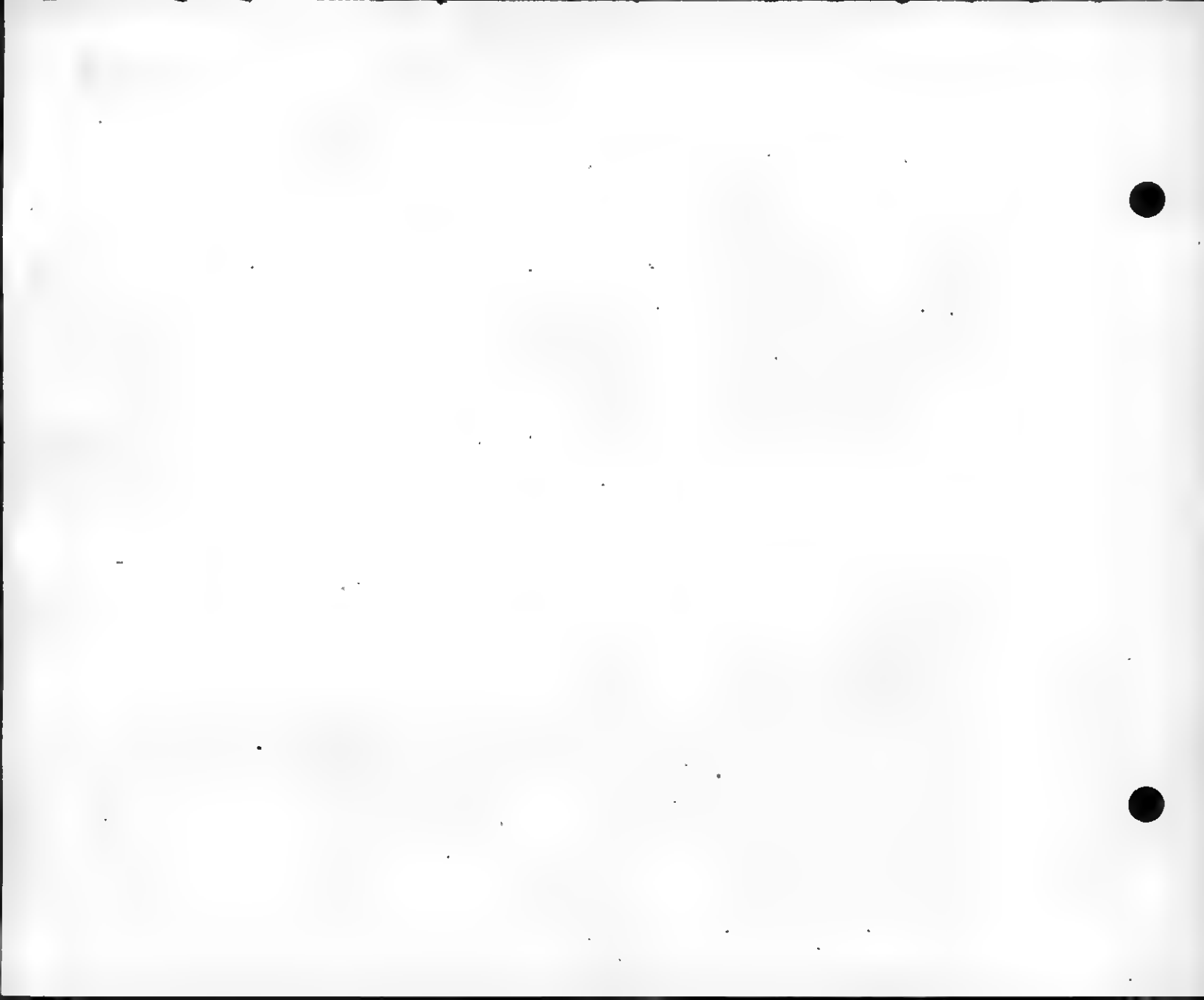
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SYKESVILLE</u> c. LENGTH OF STAY IN 1b <u>25 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>CARROLL</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SYKESVILLE</u> d. STREET ADDRESS <u>MAIN ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>DAVID W. GREEN</u> First Middle Last		4. DATE OF DEATH <u>JAN. 17 1966</u> Month Day Year	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 19 1880</u> Month Day Year
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER (Retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AGRICULTURE</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>PENNA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>THOMAS P. GREEN</u>		14. MOTHER'S MAIDEN NAME <u>MARY BOWSER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT <u>MR RICHARD GREEN - WOODBINE, Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> 42-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>Arteriosclerosis, generalized.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1960 through 1-17-66</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>19 60</u> to <u>Jan. 17</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Jan. 17</u> , 1966, and that death occurred at <u>12 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Howard E. Hann</u>		22b. DATE SIGNED <u>JAN. 15, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>HOWARD E. HANN</u>		22d. ADDRESS <u>SYKESVILLE, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>1-20-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ADDISON</u>	23d. LOCATION (City, town or county) (State) <u>ADDISON PA.</u>
24. FUNERAL DIRECTOR <u>Arthur H. Haight</u>		25a. REC'D BY REGISTRAR <u>DATE JAN 24 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>James J. Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

# MARYLAND STATE DEPARTMENT OF HEALTH

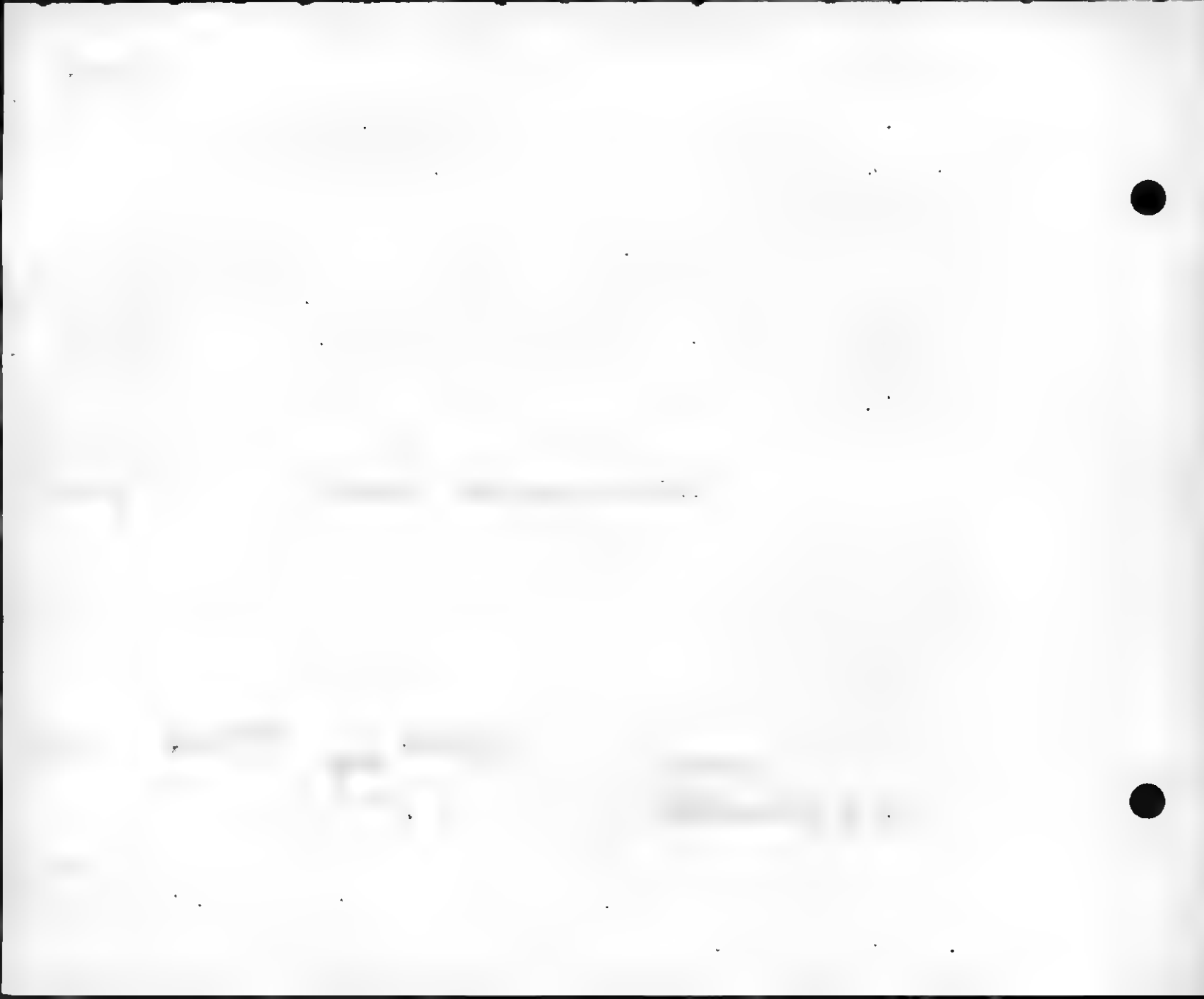
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00551

00541

<b>1. PLACE OF DEATH</b> a. COUNTY <u>CARROLL</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR RURAL</u> c. LENGTH OF STAY IN 1b <u>YEARS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) _____				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR RURAL</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>EPHRIAM THOMAS HILL</u> First Middle Last			<b>4. DATE OF DEATH</b> <u>JAN 25 1966</u> Month Day Year				
<b>5. SEX</b> <u>M</u>	<b>6. COLOR OR RACE</b> <u>COL</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>DEC 24-1877</u>	<b>9. AGE</b> (in years last birthday) <u>88</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>HOTEL LABORER</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>MARYLAND</u>			
<b>13. FATHER'S NAME</b> <u>SAMUEL HILL</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>MARGARET JOBES</u>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>NONE</u>		<b>17. INFORMANT</b> <u>ELSIE HILL NEW WINDSOR MD</u> Address			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic C.V.D.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____					<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>years.</u>		
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>					<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>		
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>7/1/50</u> , 19 <u>50</u> , <b>to</b> <u>1/25/66</u> , that (I) <u>last</u> saw the deceased alive on <u>1/24/66</u> , 19 <u>66</u> , and that death occurred at <u>4:25</u> AM, from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <u>M.E. Robertson</u>			<b>22b. DATE SIGNED</b>		<b>22c. PHYSICIAN'S NAME (Type)</b> <u>M.E. ROBERTSON</u>		
<b>22d. ADDRESS</b> <u>NEW WINDSOR MD</u>			<b>22e. REC'D BY REGISTRAR</b>				
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>			<b>23b. DATE THEREOF</b> <u>1/28/1966</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>MT OLIVE</u>		
<b>23d. LOCATION (City, town or county) (State)</b> <u>NEW WINDSOR RURAL MD</u>			<b>23e. REGISTRAR'S SIGNATURE</b> <u>J. H. Jones</u>				
<b>24. FUNERAL DIRECTOR</b> <u>W.D. Hartley &amp; Sons New Windsor</u>			<b>25. REGISTRAR'S SIGNATURE</b> <u>J. H. Jones</u>				
<b>25a. DATE</b> <u>JAN 28 1966</u>			<b>25b. REGISTRAR'S SIGNATURE</b> <u>J. H. Jones</u>				





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and at any event, within 72 hours after death.

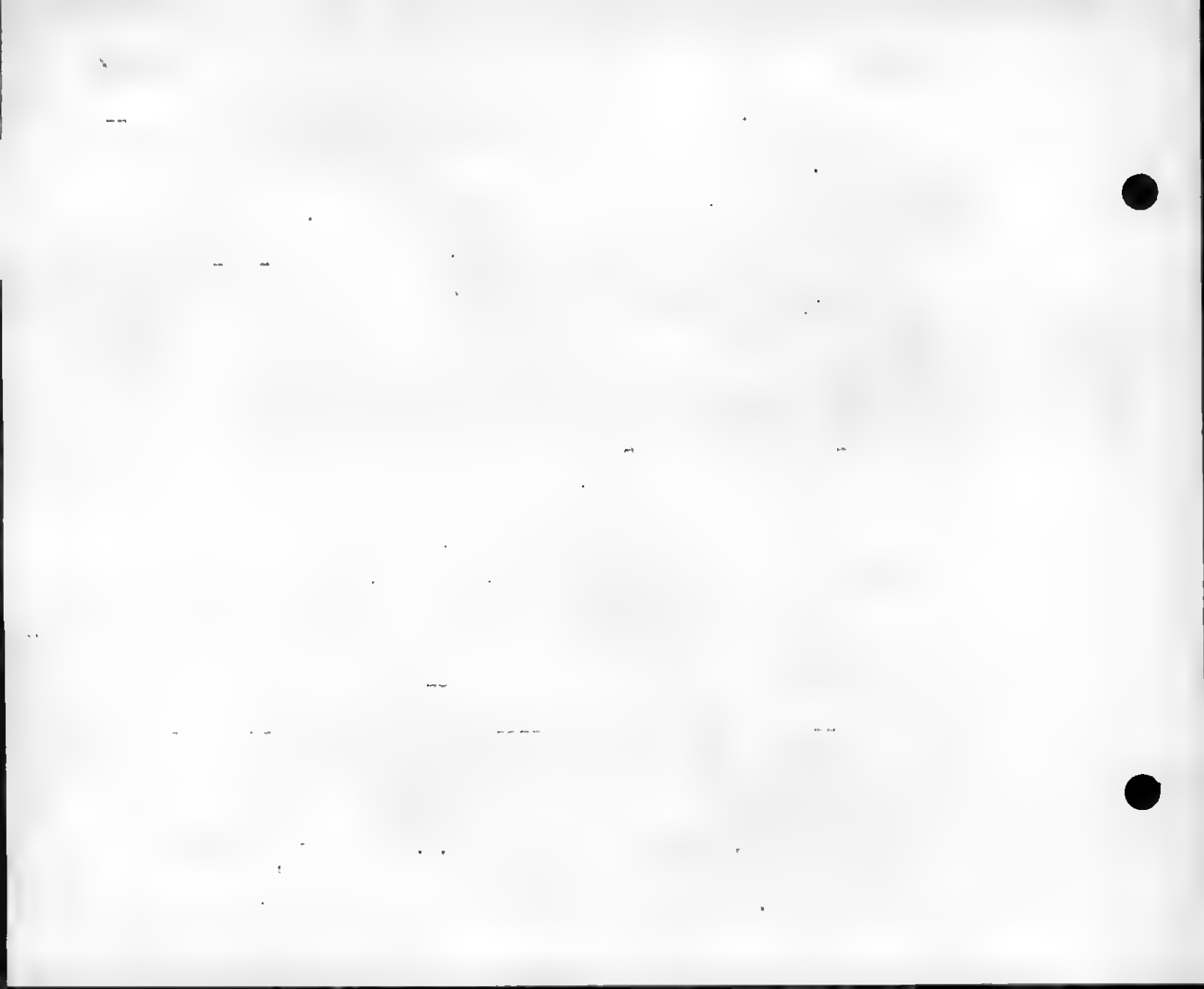
VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00552

00542

1. PLACE OF DEATH a. COUNTY <b>CARROLL CO.</b> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SYKESVILLE, MD.</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SPRINGFIELD STATE HOSPITAL</b>				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Baltimore City</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore City</b> d. STREET ADDRESS <b>1320 Morling Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Samuel</b> First <b>Himmel</b> Middle <b>Himmel</b> Last		4. DATE OF DEATH <b>1-22-66</b> Month <b>1</b> Day <b>22</b> Year <b>19</b>		5. SEX <b>male</b> 6. COLOR OR RACE <b>white</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/1/86</b> 9. AGE (In years last birthday) <b>79</b> yrs. IF UNDER 1 YEAR Months <b>2</b> Days <b>21</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>NEW YORK STATE</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Moses Himmel</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>Patients Record</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>4200</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>Generalized Arteriosclerosis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>days</b> <b>years</b> <b>years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12/3/1940</b> to <b>1/22/1966</b> , that (I) (we) last saw the deceased alive on <b>1/22/66</b> 19, and that death occurred at <b>2:15 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Samuel P. Wise</b>				22b. DATE SIGNED <b>1/22/66</b>		22c. PHYSICIAN'S NAME (Type) <b>Samuel P. Wise</b> 4th	
22d. ADDRESS <b>S.S. Hospital, Maryland</b>				22e. M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>25 Jan. 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore County, Maryland</b>	
24. FUNERAL DIRECTOR <b>Burgee Funeral Home</b> ADDRESS <b>3631 Falls Road</b>				25a. REC'D BY REGISTRAR <b>FEB 1 1966</b>		25b. REGISTRAR'S SIGNATURE <b>not a valid signature</b>	

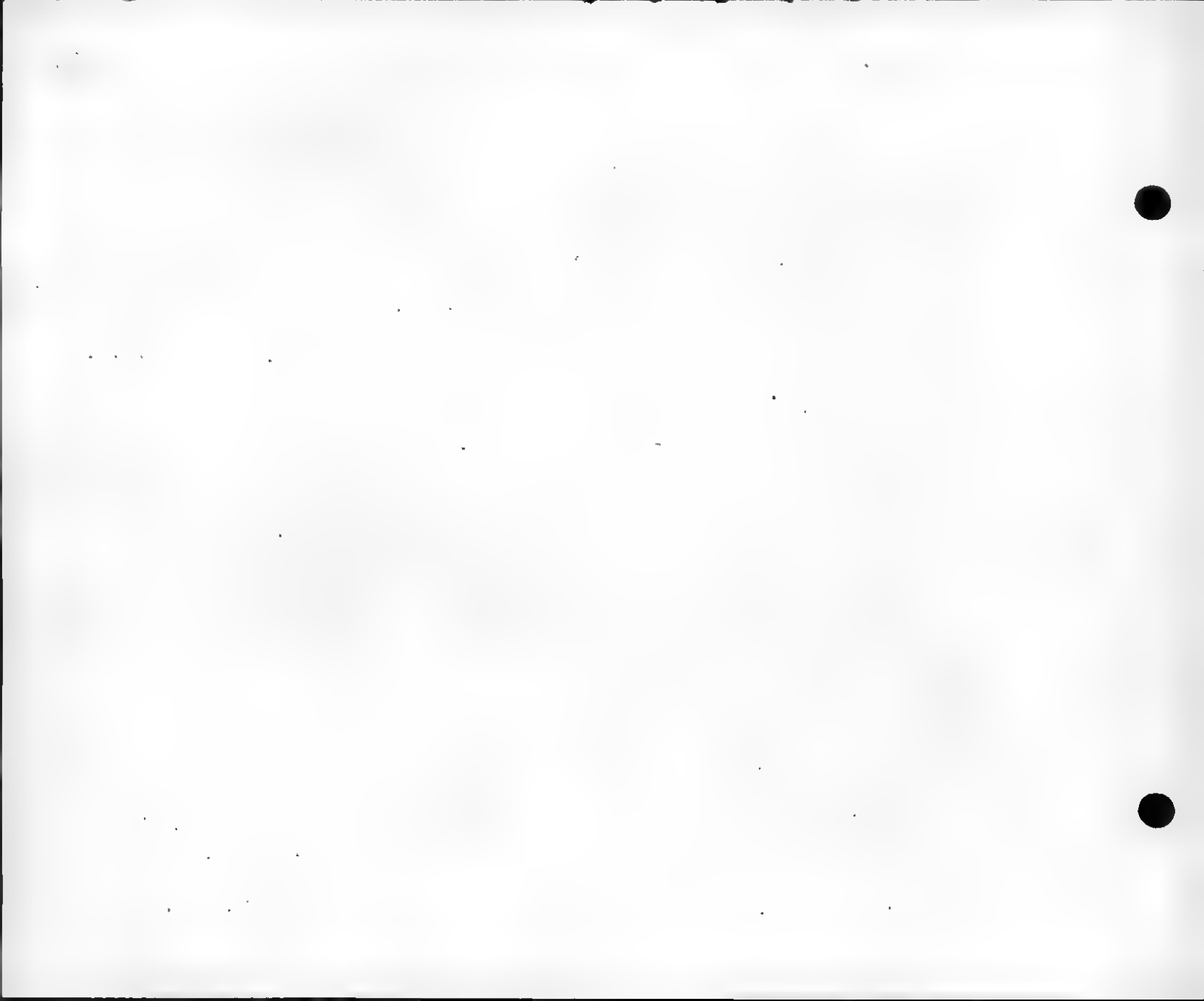


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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00553 CERTIFICATE OF DEATH 00543

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Westminster</b> c. LENGTH OF STAY IN 1b <b>5 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Carroll County General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Finksburg, RD</b> d. STREET ADDRESS <b>Box 120</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>JOHN WILLIAM HOLT</b>		4. DATE OF DEATH Month Day Year <b>January 18 1966</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 31, 1922</b>
9. AGE (In years last birthday) <b>43</b> yrs.		10. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Signal &amp; Telephone Dept. W. Md. RR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Ohio Pyle, Pnna.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John W. Holt</b>		14. MOTHER'S MAIDEN NAME <b>Susanna Cox</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes, give war or dates of service) <b>W W II</b>		16. SOCIAL SECURITY NO. <b>198-18-0123</b>	
17. INFORMANT <b>Mrs. John Wm. Holt</b>		Address <b>same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>2001</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cancer of the Stomach</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 13, 1966</b> , to <b>Jan 18, 1966</b> , that (I) (we) last saw the deceased alive on <b>Jan 18, 1966</b> , and that death occurred at <b>9:45</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>John S. Harshey</b>		22b. DATE SIGNED <b>1/18/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN S. HARSHEY, M.D.</b>		22d. ADDRESS <b>8 Anchor St. Westminster, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>		23b. DATE THEREOF <b>Jan. 22, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Samson Chapel Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Farmington, Pa.</b>	
24. FUNERAL DIRECTOR <b>J. S. Myers Jr. Westminster, Md.</b>		25a. REC'D BY REGISTRAR <b>Jan 20 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>J. Carlos Judge</b>	



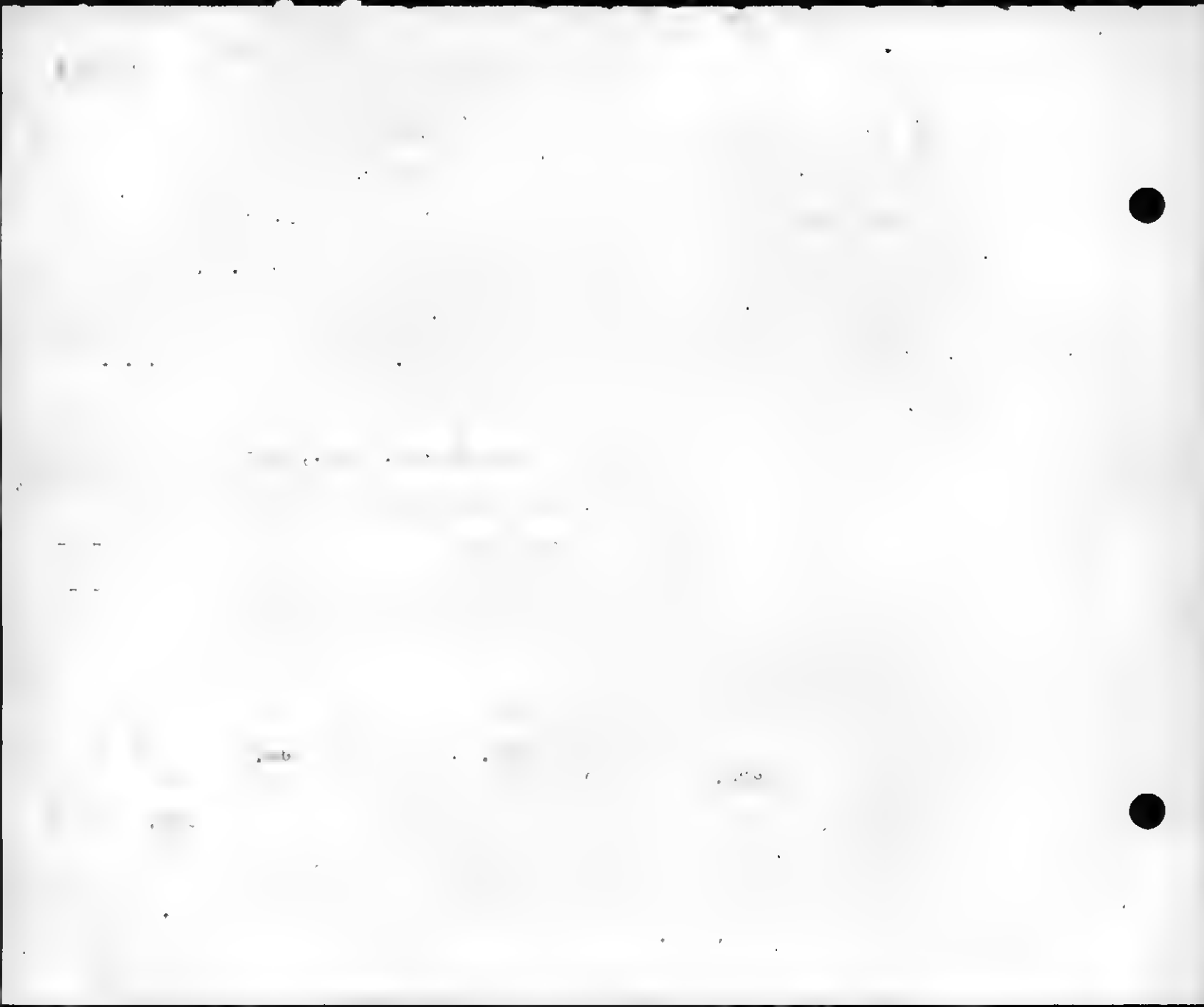
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VR A15 (4)  
20M 1/65

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>																	
<b>1. PLACE OF DEATH</b> a. COUNTY <i>Carroll</i> <i>Sykesville</i> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Sykesville</i> c. LENGTH OF STAY IN ID  d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Pullen Nursing Home</i>					<b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Carroll</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i> d. STREET ADDRESS <i>1329 Dalton Road #34</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
<b>3. NAME OF DECEASED</b> (Type or print) <i>Anna</i>			First <i>Anna</i> Middle <i>Houdek</i> Last <i>Houdek</i>		<b>4. DATE OF DEATH</b> Month <i>Jan.</i> Day <i>5</i> Year <i>1966</i>			<b>5. SEX</b> <i>female</i>									
<b>6. COLOR OR RACE</b> <i>white</i>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <i>May 24, 1878</i>		<b>9. AGE</b> (In years last birthday) <i>87</i> yrs. <table border="1"> <tr> <th>Months</th> <th>Days</th> <th>Hours</th> <th>Min.</th> </tr> <tr> <td></td> <td></td> <td></td> <td></td> </tr> </table>		Months	Days	Hours	Min.					<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>housewife</i>	
Months	Days	Hours	Min.														
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <i>home</i>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <i>Czech.</i>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <i>U.S.A.</i>			<b>13. FATHER'S NAME</b> <i>Frank Korechey</i>									
<b>14. MOTHER'S MAIDEN NAME</b> <i>Unknown</i>			<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <i>no</i>			<b>16. SOCIAL SECURITY NO.</b> <i>none</i>		<b>17. INFORMANT</b> <i>Mary Sikora, dght., above</i>									
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerosis generalized, diabetes</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Gangrene of left foot</i> DUE TO (c) <i>Carcinoma of left cheek</i>									<b>INTERVAL BETWEEN ONSET AND DEATH</b> <i>11-28-64</i>  <i>1-5-66</i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>								
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)														
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <i>19</i>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)											
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <i>Nov. 28</i> , 19 <i>64</i> , to <i>Jan 5</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>Jan. 5</i> , 19 <i>66</i> , and that death occurred at <i>5 AM</i> , from the causes and on the date stated above.																	
<b>22a. SIGNATURE</b> <i>Howard E. Hall</i>						<b>22b. DATE SIGNED</b> <i>Jan. 5, 1966</i>											
<b>22c. PHYSICIAN'S NAME</b> (Type) <i>Howard E. Hall MD</i>			<b>22d. ADDRESS</b> <i>Sykesville, Maryland</i>														
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <i>Burial</i>		<b>23b. DATE THEREOF</b> <i>1/8/66</i>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <i>Holy Redeemer Cemetery</i>		<b>23d. LOCATION</b> (City, town or county) (State) <i>Baltimore, Md.</i>											
<b>24. FUNERAL DIRECTOR</b> <i>Schlimmer Funeral Home, Inc.</i> <i>3331 Brehms Lane #13</i>				<b>25a. REC'D BY REGISTRAR</b> <i>JAN 10 1966</i>		<b>25b. REGISTRAR'S SIGNATURE</b> <i>Charles Judge</i>											

MEDICAL CERTIFICATION



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

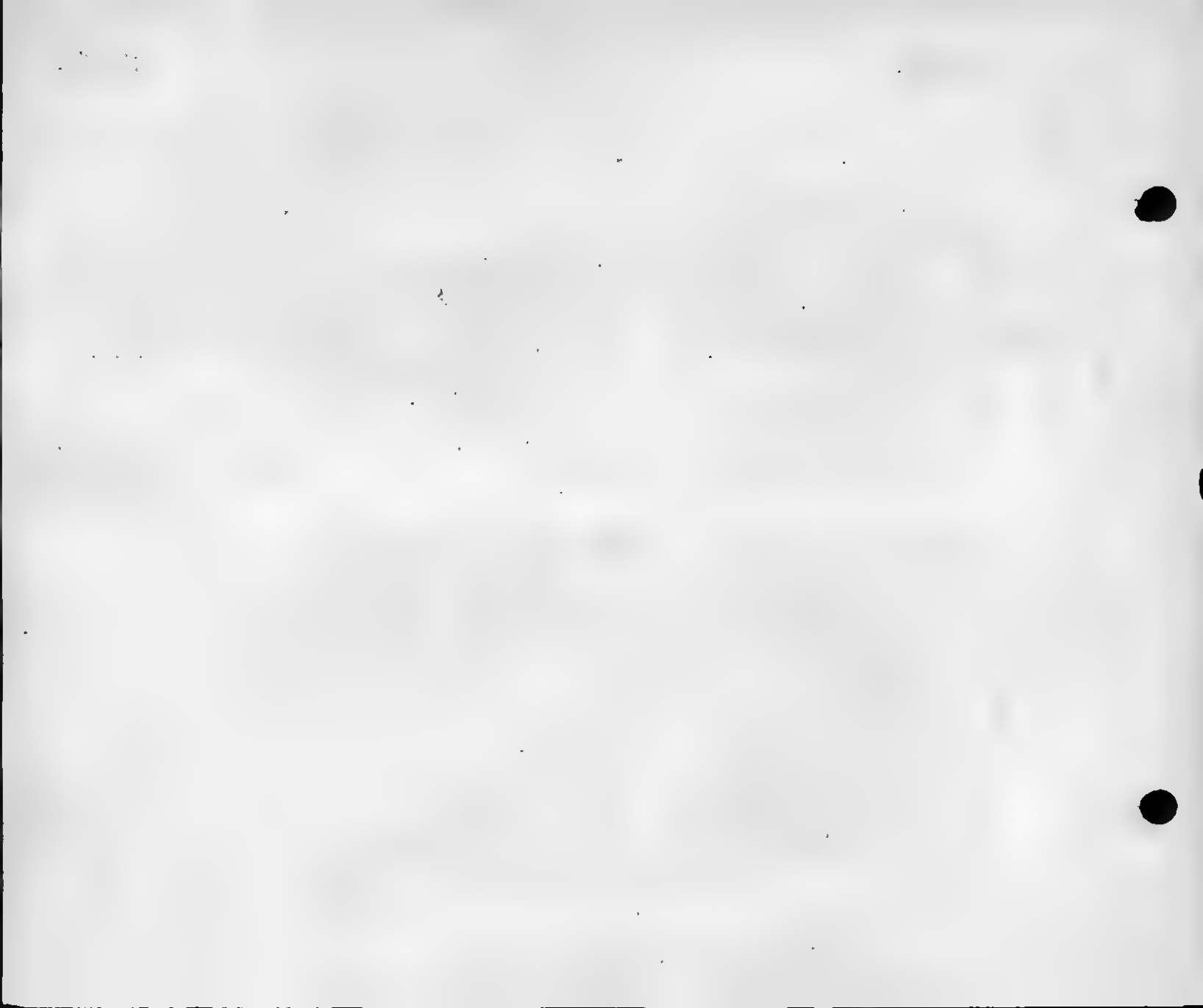
## CERTIFICATE OF DEATH

00555

00545

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Carroll</u> <span style="float: right;"><b>MARYLAND</b></span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> <span style="float: right;">c. LENGTH OF STAY IN 1b <u>18 Months</u></span> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Glover Nursing Home</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Balto. City</u></span> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u> d. STREET ADDRESS <u>2623 Cold Spring Lane</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Mamie</u> <span style="float: right;">First Middle Last</span> <b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>Cau.</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>October 11, 1884</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>4. DATE OF DEATH</b> Month <u>January</u> Day <u>18</u> Year <u>1966</u> <b>9. AGE</b> (In years last birthday) <u>81</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS.: Hours <u>  </u> Min. <u>  </u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired Saleslady</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Department Store</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Baltimore, Maryland</u>			
<b>13. FATHER'S NAME</b> <u>Charles Kagler</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary J.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT</b> <u>Frank A. Kagler</u> <span style="float: right;">Address <u>21234</u> <u>7827 Birmingham Ave.</u></span>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-vascular accident</u> <u>331X</u> DUE TO (b) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) <u>  </u>				INTERVAL BETWEEN ONSET AND DEATH <u>25 min.</u>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>			
<b>20f. (City or town)</b> <u>  </u>		<b>20g. (County)</b> <u>  </u>		<b>20h. (State)</b> <u>  </u>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>May 31, 1964</u> <b>to</b> <u>Jan 18, 1966</u> <b>that (I) (we) last saw the deceased alive on</b> <u>Jan 12, 1966</u> <b>and that death occurred at</b> <u>9:30 AM</u> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>E. Reese Wilkens</u>		<b>22b. DATE SIGNED</b> <u>Jan 20, 1966</u>		<b>22c. PHYSICIAN'S NAME (Type)</b> <u>E. Reese WILKENS</u>			
<b>22d. ADDRESS</b> <u>15 Temper Westminster Md</u>		<b>22e. MED. DIRECTOR</b> <input checked="" type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>					
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>January 21/66</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Mt. Carmel Cemetery</u>			
<b>23d. LOCATION (City, town or county)</b> <u>Baltimore City</u>		<b>23e. (State)</b> <u>Maryland</u>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John E. Hoff</u>		<b>ADDRESS</b> <u>Hampstead, Maryland</u>		<b>25a. REC'D BY REGISTRAR</b> <u>  </u>			
<b>25b. REGISTRAR'S SIGNATURE</b> <u>  </u>		<b>DATE</b> <u>Jan 24 1966</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



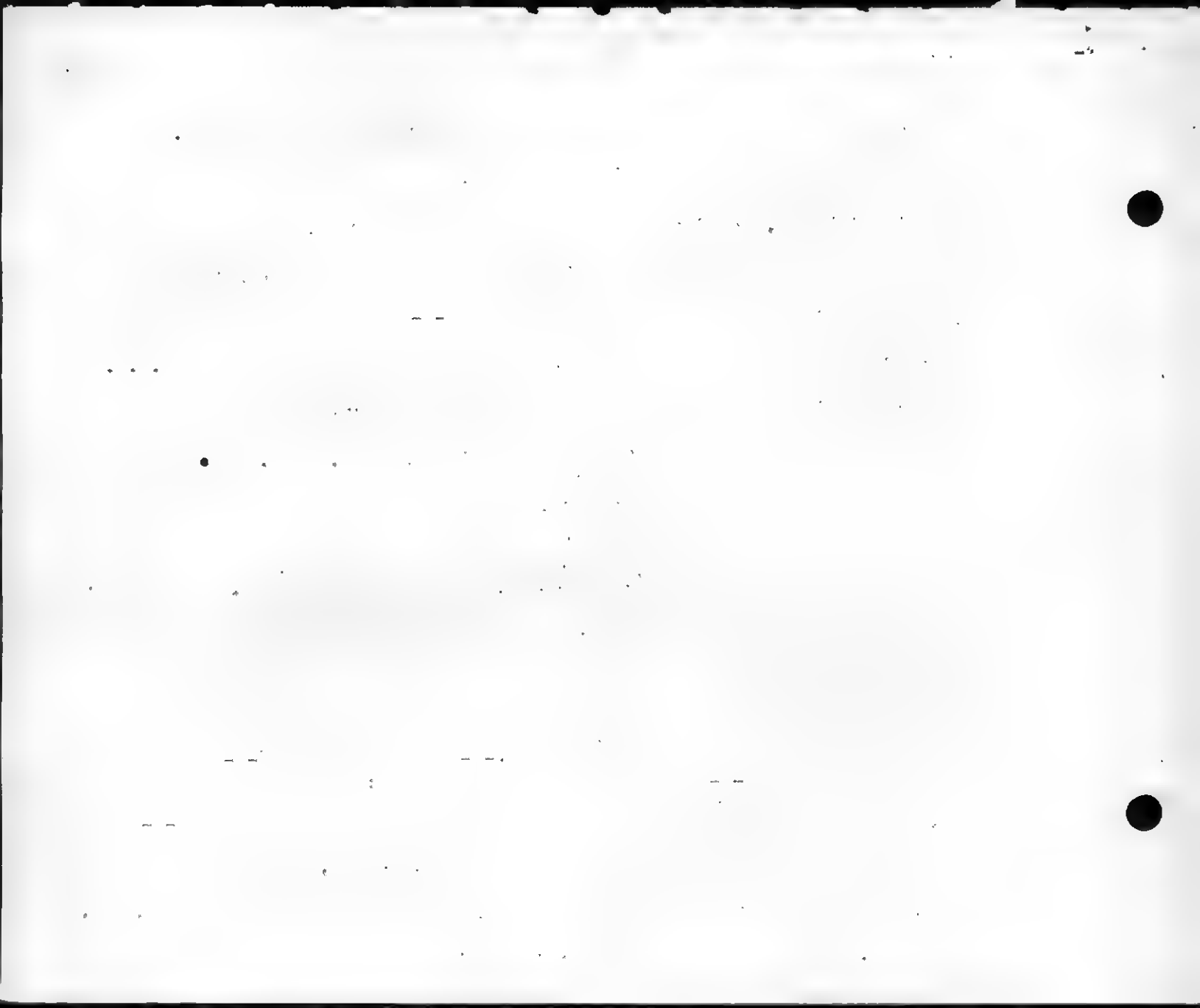


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN ID <b>18 Months</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Mont.</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>		d. STREET ADDRESS <b>3515 Tayler street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>George Joseph Keating</b>		First		Middle		Last		4. DATE OF DEATH <b>January 9 19 66</b>		Month		Day			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-9-05</b>		9. AGE (In years last birthday) <b>60 yrs.</b>		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>0</b>		11. IF UNDER 24 HRS. Hours <b>0</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Lawyer</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <b>New York</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Patrick Keating</b>						14. MOTHER'S MAIDEN NAME <b>Frances Cunningham</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Unknown</b>				16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT <b>Springfield St. Hosp. Records</b>				Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure.</b> <b>4201</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary arteriosclerosis.</b> (c) <b>Numerous large gangrenous and infected decubitus ulcers and extreme emaciation.</b>												INTERVAL BETWEEN ONSET AND DEATH <b>days</b> <b>years</b> <b>months</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic brain syndrome of unknown cause without qualifying phrase.</b> <b>(Parkinson Disease)</b>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>7-8-</b> , 19 <b>64</b> , to <b>1-9-</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>1-9-</b> , 19 <b>66</b> , and that death occurred <b>3:35AM</b> , from the causes and on the date stated above.															
22a. SIGNATURE <b>Frances Reid Nabors</b>										22b. DATE SIGNED <b>1-9-66</b>					
22c. PHYSICIAN'S NAME (Type) <b>Frances Reid Nabors</b>						22d. ADDRESS <b>Sykesville, Maryland</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>1-11-66 Burial</b>				23b. DATE THEREOF <b>1-11-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cem.</b>				23d. LOCATION (City, town or county) (State) <b>Silver Spring, Md.</b>					
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY</b>						ADDRESS <b>Bethesda, Maryland</b>				25a. REC'D BY REGISTRAR <b>JAN 13 1966</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

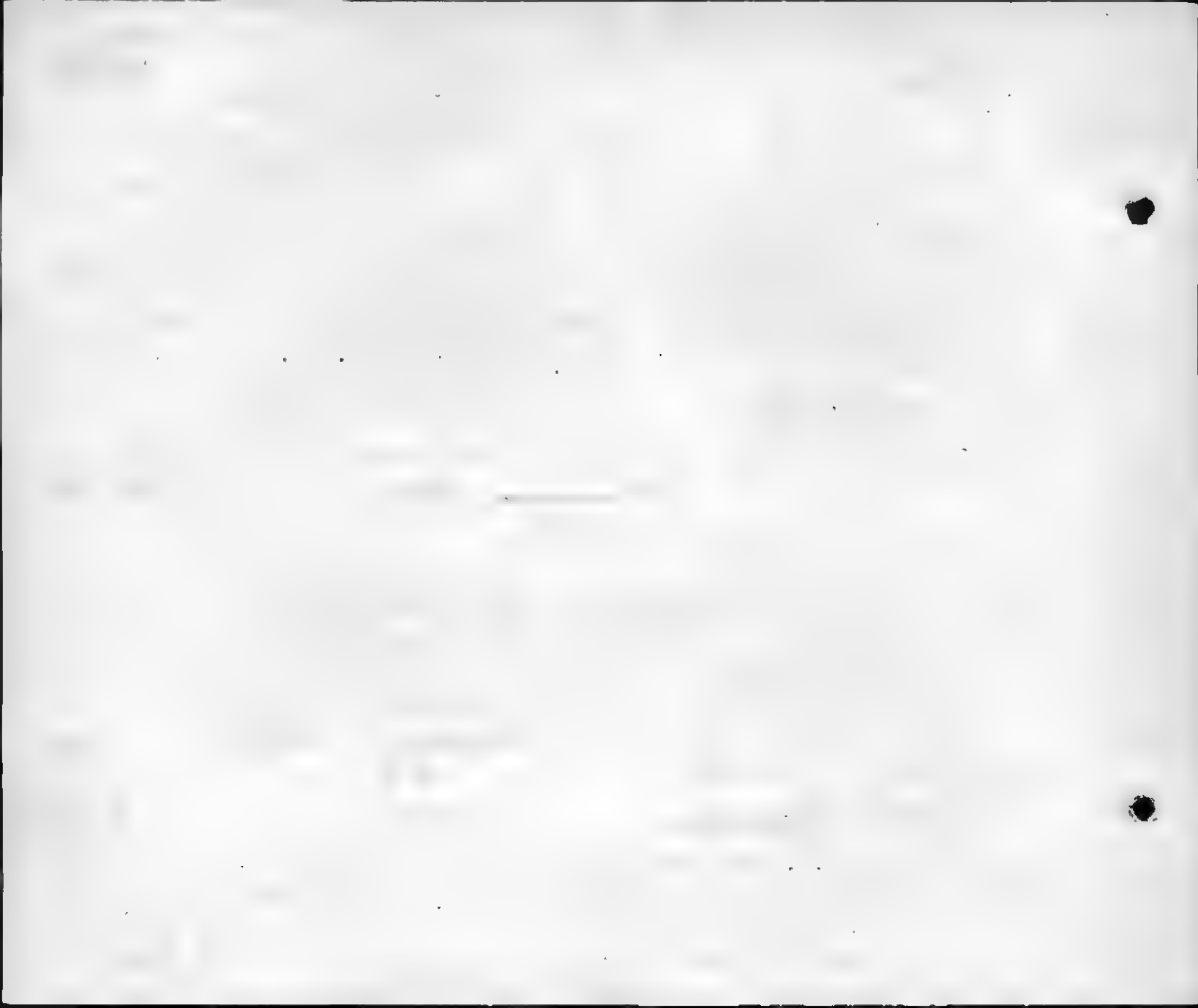


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

Item 18 Film G375 4 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00557 CERTIFICATE OF DEATH 00547

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Sykesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Sykesville</u>	
c. LENGTH OF STAY IN 1b <u>Life</u>		d. STREET ADDRESS <u>R.F.D.# 2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>R.F.D.# 2</u>		e. 15 RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>STERLING D. KNAUFF</u>		4. DATE OF DEATH <u>Jan. 19 19 66</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 6 1915</u>	
9. AGE (In years last birthday) <u>50</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Carroll Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John J. Knauff</u>		14. MOTHER'S MAIDEN NAME <u>Grace A. Keefer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-14-2994</u>	
17. INFORMANT <u>Mrs Ethel S. Knauff</u>		Address <u>Same as # 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Carcinomatous</u> DUE TO (b) <u>Primary site unknown</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>442</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u>32 days</u> INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11/28/65</u> 19 to <u>11/19/66</u> 19, that (I) <u>last</u> saw the deceased alive on <u>11/17/66</u> 19, and that death occurred at <u>8 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>M.E. Robertson</u>		22b. DATE SIGNED <u>11/19/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>M.E. Robertson</u>		22d. ADDRESS <u>New Windsor, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 22 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Sams Creek Brethren</u>		23d. LOCATION (City, town or county) (State) <u>Carroll Co. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>C.M. Waltz</u>		25a. REC'D BY REGISTRAR <u>JAN 21 1966</u>	
ADDRESS <u>Box 241 Sykesville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>John W. Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Page 5 may be retained by the funeral director. After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

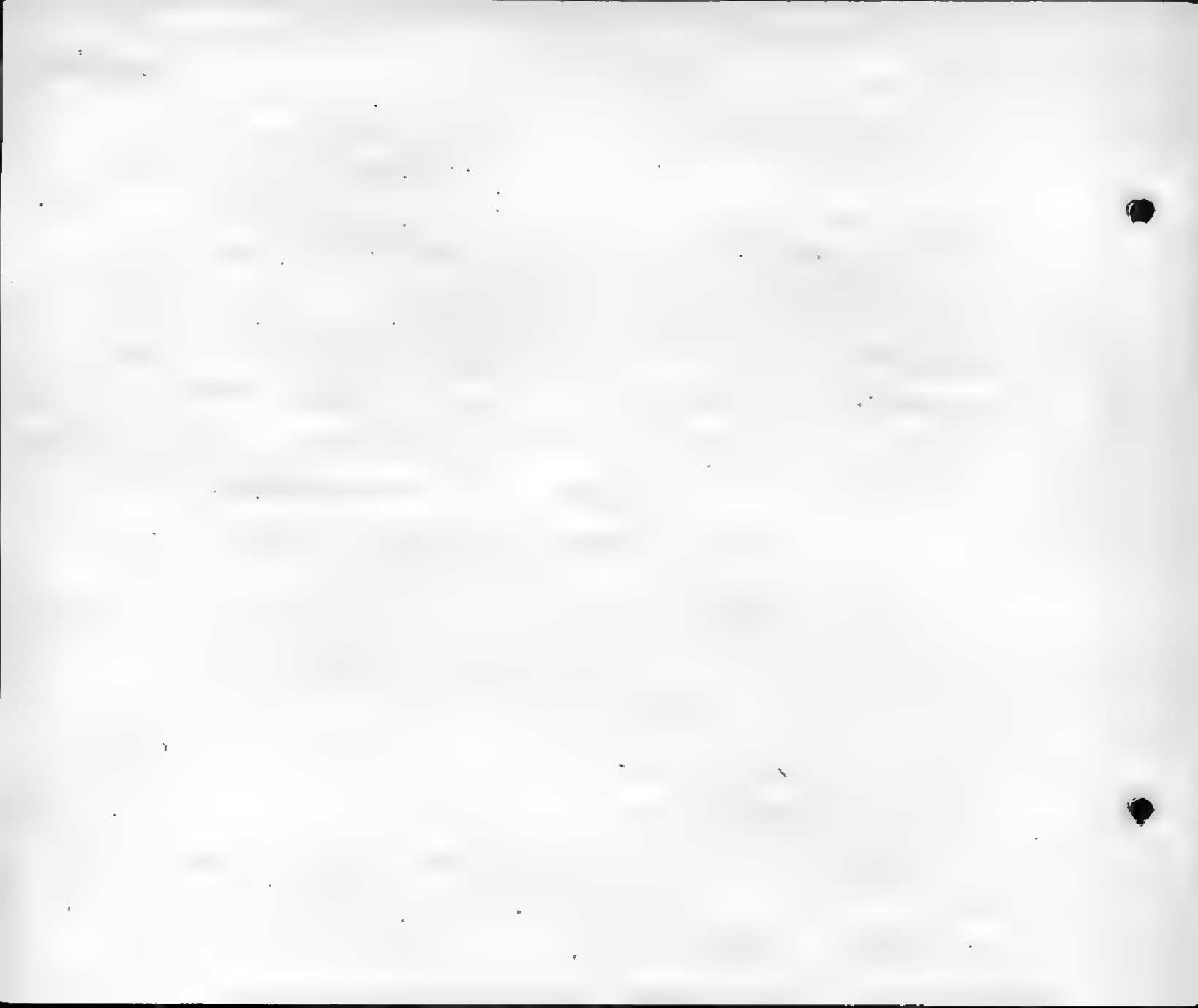
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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00558

00548

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAMPSTEAD</u>				c. LENGTH OF STAY IN 1b <u>40</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>127 Sunset Drive</u>				d. STREET ADDRESS <u>127 Sunset Drive</u>			
3. NAME OF DECEASED (Type or print) <u>CRACHEY ANN LEISTER</u>				4. DATE OF DEATH Month <u>JAN</u> Day <u>4</u> Year <u>1966</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN 17 1896</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>Cannoll Co, Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>HARVEY H. ENSOR</u>				14. MOTHER'S MAIDEN NAME <u>Laura ANN Hale</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u>217-28-6145</u>			
17. INFORMANT <u>V. Kenneth Leister</u>				Address <u>HAMPSTEAD MD</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Bladder (metastatic)</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Primary Anemia Left Ventricle &amp; Metastases</u> DUE TO (c) <u>2 1/2 years</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>7-4</u> <u>1966</u> to <u>1-4</u> <u>1966</u> , that (I) (we) last saw the deceased alive on <u>JAN 3</u> <u>1966</u> , and that death occurred at <u>4:30</u> <u>PM</u> , from the causes and on the date stated above				22a. SIGNATURE <u>Joseph E. Bush</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u>			
22b. DATE SIGNED <u>1/4/66</u>				22d. ADDRESS <u>HAMPSTEAD Maryland</u>			
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>1-7-66</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Mem. Gardens</u>				23d. LOCATION (City, town or county) (State) <u>Finksburg MD.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Tipton-Eline</u>				25a. REC'D BY REGISTRAR <u>JAN 10 1966</u>			
ADDRESS <u>Hampstead, Md.</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>																
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Carroll</u> <span style="float: right;">00559</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Eldersburg</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Liberty and Oklahoma roads</u>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">00549</span> b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>2308 Sidney Ave.</u> <u>21230</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Charles</u> Middle <u>R.</u> Last <u>Leutner</u>			<b>4. DATE OF DEATH</b> Month <u>Jan</u> Day <u>5</u> Year <u>1966</u>			<b>5. SEX</b> <u>Male</u>			<b>6. COLOR OR RACE</b> <u>White</u>							
<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>			<b>8. DATE OF BIRTH</b> <u>Oct. 7, 1888</u>			<b>9. AGE</b> (In years last birthday) <u>77</u> yrs. <table border="1"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td></td> <td>Hours</td> </tr> <tr> <td></td> <td>Min.</td> </tr> </table>			IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days		Hours		Min.
IF UNDER 1 YEAR	IF UNDER 24 HRS.															
Months	Days															
	Hours															
	Min.															
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Clerk</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Hardware Store</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Baltimore, Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b>								
<b>13. FATHER'S NAME</b> <u>Henry Leutner</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Pauline</u>										
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b> <u>213-14-3588</u>		<b>17. INFORMANT</b> <u>Mr. Richard F. Leutner</u>		<b>Address</b> <u>2308 Sidney Ave. Baltimore, Md. 30</u>								
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Pneumonia</u> (b) <u>Chronic Heart Failure</u> (c) <u>Pulmonary TBC</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Neurotic Depression</u>										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>4 days</u> <u>4 weeks</u> <u>7</u>						
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.)												
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>a.m.</u> <u>p.m.</u> <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)								
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Dec. 23</u> , 19 <u>65</u> , <b>to</b> <u>Dec. 31</u> , 19 <u>65</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>Jan 5</u> 19 <u>66</u> <b>and that death occurred at</b> <u>2:30 PM</u> <b>from the causes and on the date stated above.</b>																
<b>22a. SIGNATURE</b> <u>Sani Grudman</u>						<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>1/1/66</u>								
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Sani A. Grudman, M. D.</u>						<b>22d. ADDRESS</b> <u>Obrecht Rd. Sykesville, Md.</u>										
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>1/8/1966</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Loudon Park Cemetery</u>		<b>23d. LOCATION (City, town or county)</b> (State) <u>Baltimore, Md.</u>								
<b>24. FUNERAL DIRECTOR</b> <u>Wm. J. Tiekner &amp; Son</u>				<b>ADDRESS</b> <u>Balto., Md.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>Charles Judge</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>								
<b>DATE</b> <u>JAN 6 1966</u>																





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VR A15 (4)  
 2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
 CERTIFICATE OF DEATH

00560

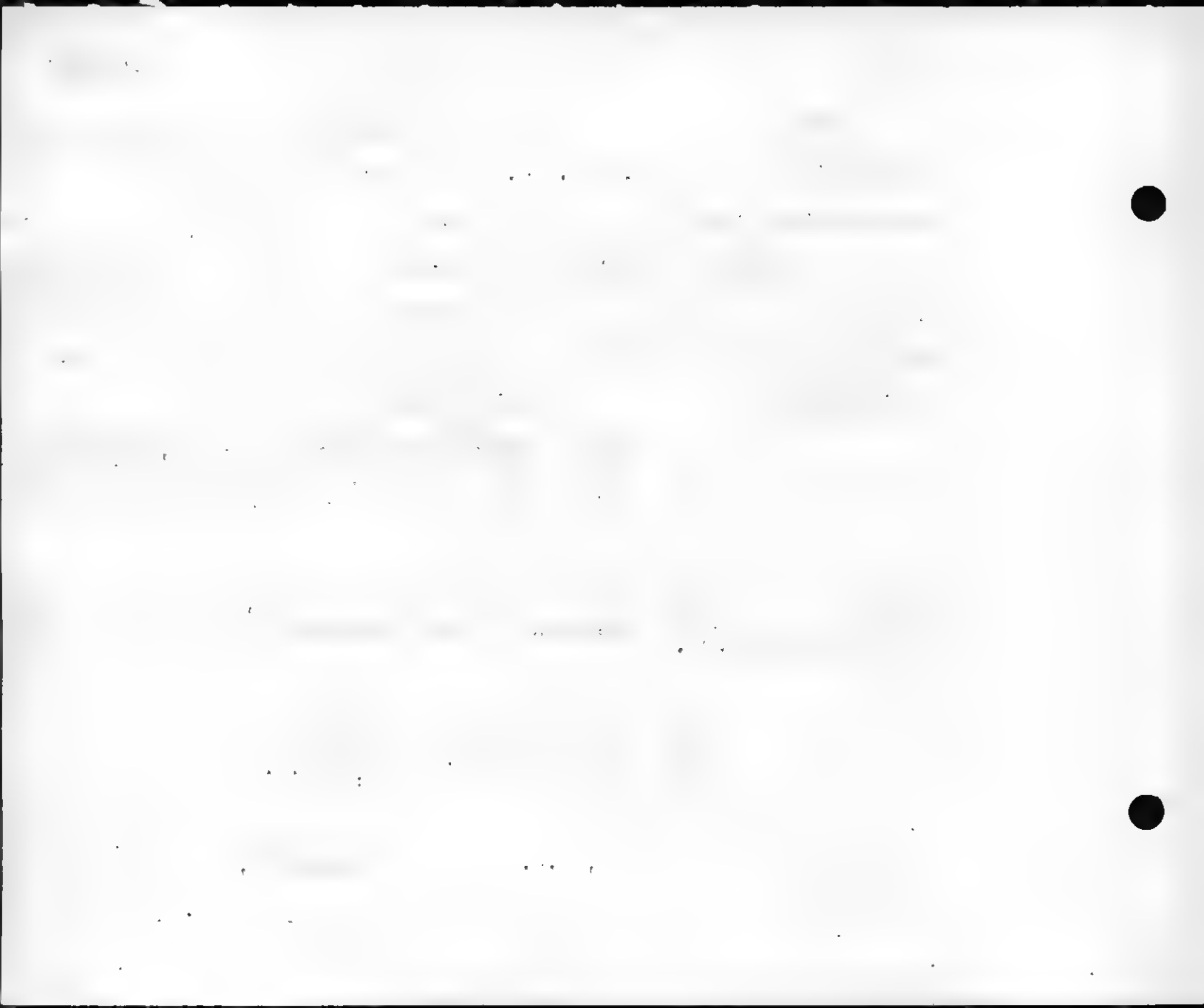
00550

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural--Sykesville</b> c. LENGTH OF STAY IN 1b <b>6y. 11m. 1d.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Springfield State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Boonesboro</b> d. STREET ADDRESS <b>Route #2</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Carrie</b> Middle <b>Edith</b> Last <b>Martz</b>		4. DATE OF DEATH Month <b>1</b> Day <b>18</b> Year <b>1966</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/8/92</b>
9. AGE (In years last birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR: Months <b>12</b> Days <b>12</b> Hours <b>12</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Franklin Bowers</b>		14. MOTHER'S MAIDEN NAME <b>Jennie Sumam</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Springfield Hospital records, Sykesville</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> (b) <b>Senility</b> (c) <b>Chronic brain syndrome of unknown or unspecified cause with psychotic reaction.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic brain syndrome of unknown or unspecified cause with psychotic reaction.</b> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that <del>the</del> (this hospital) attended the deceased from <b>2/17/1959</b> to <b>1/18/1966</b> , that <del>we</del> (we) last saw the deceased alive on <b>1/18/1966</b> , and that death occurred at <b>6:49 p.m.</b> from the causes and on the date stated above. 22a. SIGNATURE <b>Fausto Acosta Natal, M.D.</b> 22b. DATE SIGNED <b>1/18/66</b> 22c. PHYSICIAN'S NAME (Type) <b>Fausto Acosta Natal, M.D.</b> 22d. ADDRESS <b>Springfield State Hospital Sykesville, Maryland</b> 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>Jan 20 1966</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Boonesboro</b> 23d. LOCATION (City, town or county) (State) 24. FUNERAL DIRECTOR <b>Boonesboro</b> 25a. REC'D BY REGISTRAR <b>Boonesboro</b> 25b. REGISTRAR'S SIGNATURE <b>Boonesboro</b>			

MEDICAL CERTIFICATION

762

MD



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00561 <span style="float: right;">00551</span>									
1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> c. LENGTH OF STAY IN 1b <b>3yrs. 7mos. 7dys.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>3401 Menlo Drive</b>				
3. NAME OF DECEASED (Type or print) First <b>IRVIN</b> Middle <b>JOSEPH</b> Last <b>MCCURRY</b>					4. DATE OF DEATH Month <b>JANUARY</b> Day <b>21</b> Year <b>1966</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4-16-11</b>		9. AGE (In years last birthday) <b>54</b> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Painter</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John A. McCurry</b>					14. MOTHER'S MAIDEN NAME <b>Mary L. Cullen</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Records, Springfield State Hospital</b>			Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral lobar pneumonia</b> <b>490X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Schizophrenic reaction, simple type</b>									INTERVAL BETWEEN ONSET AND DEATH <b>Days</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>6-14-35</b> , 19____, to <b>1-21-66</b> , 19____, that (I) (we) last saw the deceased alive on <b>1-21-66</b> , 19____, and that death occurred at <b>2:30 AM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Frances Reid Nabors</b>					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>Jan 21, 1966</b>		
22c. PHYSICIAN'S NAME (Type) <b>Frances Reid Nabors, M. D.</b>					22d. ADDRESS <b>Springfield State Hospital Sykesville, Maryland</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>1-24-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>		
24. FUNERAL DIRECTOR <b>Vernon Lemmon</b>					25a. REC'D BY REGISTRAR <b>Jan 25 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

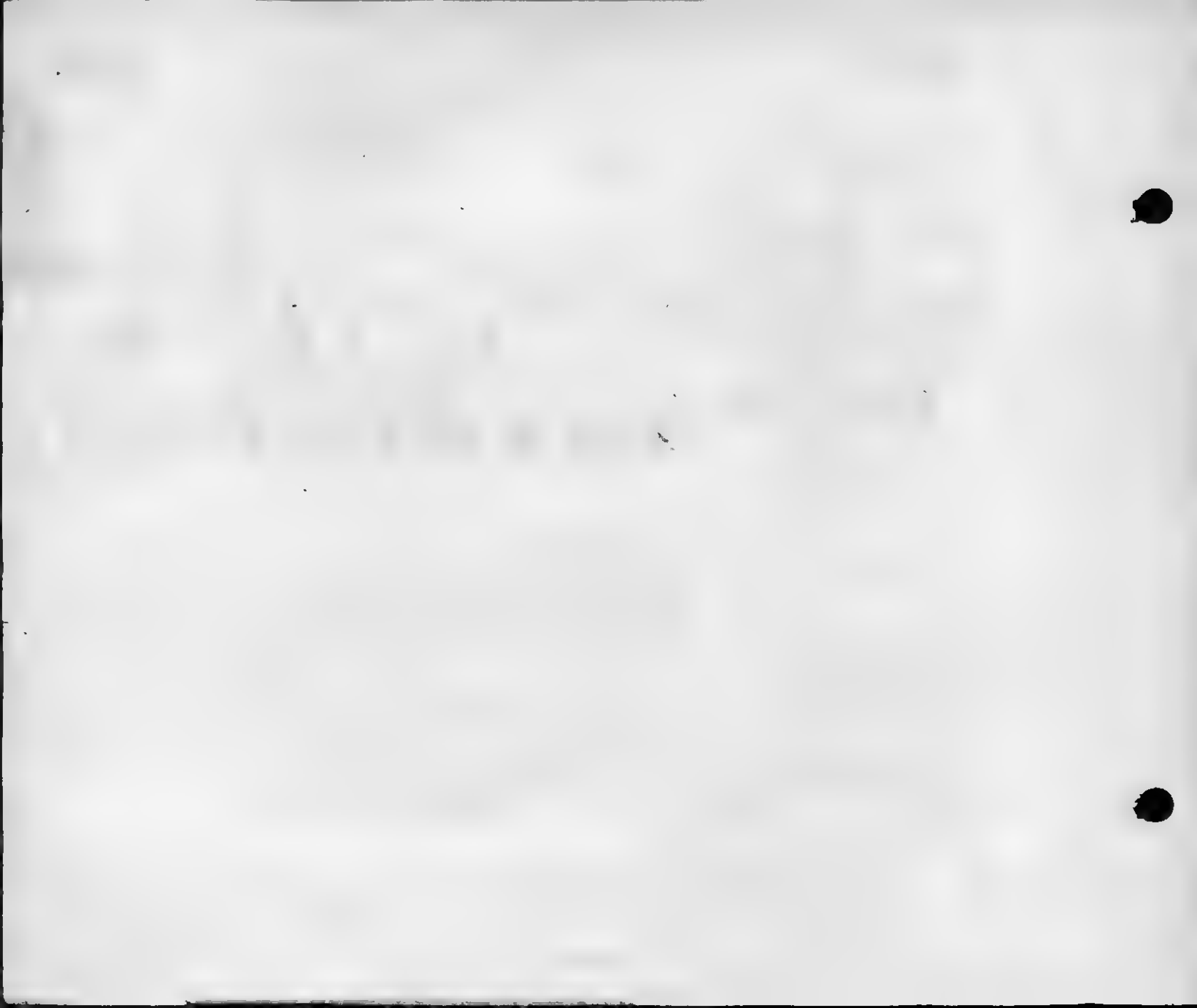
## CERTIFICATE OF DEATH

00562

00552

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Carroll</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u> c. LENGTH OF STAY IN 1b <u>2 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Long View Nursing Home Inc</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>York</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New Freedom</u> d. STREET ADDRESS <u>W. Franklin St</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>McNamee, Cleveland</u>		f. FIRST <u>Ada</u>		<b>4. DATE OF DEATH</b> Month <u>Jan</u> Day <u>26</u> Year <u>1966</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Jan 16, 1885</u>					
<b>9. AGE</b> (In years last birthday) <u>81</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <u>8</u> Days <u>10</u>		<b>11. IF UNDER 24 HRS.</b> Hours <u>10</u> Min. <u>00</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>					
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>-</u>							
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Baltimore Co Maryland</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>							
<b>13. FATHER'S NAME</b> <u>Frank P Gore</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary E. Gore</u>							
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b> <u>198-362854</u>							
<b>17. INFORMANT</b> Address <u>New Freedom, Pa.</u>				<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1) Inter-arterio-venous Cardio Vascular Disease</u> <u>260 X</u> DUE TO (b) <u>2) Diabetes mellitus -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>-</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u> <u>5 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Jaundice</u>											
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>-</u>							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>19</u> e.m. <u>30</u> p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		<b>20f. (City or town)</b> (County) (State) <u>New Freedom, Pa.</u>					
<b>21. I certify that (1) (this hospital) attended the deceased from Jan 1964 to Jan 26, 1966, that (1) (we) last saw the deceased alive on 1/22/66, and that death occurred at 3:30 PM, from the causes and on the date stated above.</b>											
<b>22a. SIGNATURE</b> <u>W. H. Ford</u>				<b>22b. DATE SIGNED</b> <u>Jan 26, 1966</u>		<b>22c. PHYSICIAN'S NAME</b> (Type) <u>W. H. Ford M.D.</u>					
<b>22d. ADDRESS</b> <u>New Freedom, Pa.</u>				<b>22e. MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>							
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>Jan 29, 1966</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>New Freedom Cemetery</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>New Freedom, Penna</u>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Jacob Hartenstein</u>				<b>25a. REC'D BY REGISTRAR</b> <u>Feb 1 1966</u>							
<b>25b. REGISTRAR'S SIGNATURE</b> <u>-</u>				<b>25c. REGISTRAR'S SIGNATURE</b> <u>-</u>							

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BAP

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00563

00553

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> c. LENGTH OF STAY IN 1b <b>28yrs. 1mo. 25dys.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Springfield State Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>1508 Marshall St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>LORETTA</b>		First <b>(NMN)</b>		Middle <b>McNAMEE</b>		Last <b>McNAMEE</b>		4. DATE OF DEATH Month <b>JANUARY 12</b> Day <b>19</b> Year <b>66</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-1-01</b>		9. AGE (In years last birthday) <b>64</b> yrs. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George McNamee</b>				14. MOTHER'S MAIDEN NAME <b>Anna Tighe</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Records, Springfield State Hospital</b> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> + d d l Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>DUE TO</b> (c) <b>DUE TO</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic brain syndrome assoc. with convulsive disorder, with psychotic reaction</b>								INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>11-17-37</b> , 19 <b>37</b> , to <b>1-12-66</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>1-12-66</b> , 19 <b>66</b> , and that death occurred at <b>9:00 PM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Dr. Antonius Glahn</b>				22b. DATE SIGNED <b>1-13-66</b>		22c. PHYSICIAN'S NAME (Type) <b>Antonius Glahn, M.D.</b>			
22d. ADDRESS <b>Springfield State Hospital Sykesville, Maryland</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>1/15/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cathedral</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore</b>			
24. FUNERAL DIRECTOR <b>McCully - 130 E. Ford St.</b>				25a. REC'D BY REGISTRAR <b>1 JAN 17 1966</b>		25b. REGISTRAR'S SIGNATURE <b>James Judge</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>											
<b>1. PLACE OF DEATH</b> <b>a. COUNTY</b> <i>Carroll</i> <b>b. CITY OR TOWN</b> (If outside corporate limits, write RURAL and give nearest town) <i>Westminster</i> <b>c. LENGTH OF STAY IN 1b</b> <i>D.O.A.</i> <b>d. NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital, give street address) <i>Carroll County General Hospital</i>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) <b>a. STATE</b> <i>Maryland</i> <b>b. COUNTY</b> <i>Carroll</i> <b>c. CITY OR TOWN</b> (If outside corporate limits, write RURAL and give nearest town) <i>Westminster RD #2</i> <b>d. STREET ADDRESS</b> <i>Meadow Branch Road</i> <b>e. IS RESIDENCE ON A FARM?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) <i>HARRY PAUL MORELOCK</i>				<b>4. DATE OF DEATH</b> Month <i>JANUARY</i> Day <i>30</i> Year <i>1966</i>				<b>5. SEX</b> <i>Male</i> <b>6. COLOR OR RACE</b> <i>White</i> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <i>May 16, 1893</i> <b>9. AGE</b> (in years last birthday) <i>72 yrs.</i> <b>IF UNDER 1 YEAR</b> Months <i>72</i> Days <i>0</i> <b>IF UNDER 24 HRS.</b> Hours <i>0</i> Min. <i>0</i>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Farmer</i> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <i>-</i>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <i>Carroll Co. Maryland</i> <b>12. CITIZEN OF WHAT COUNTRY?</b> <i>U.S.A.</i>				<b>13. FATHER'S NAME</b> <i>Geoff Q. Morelock</i> <b>14. MOTHER'S MAIDEN NAME</b> <i>Elizabeth Higgard</i>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <i>-</i> (If yes give war or dates of service) <i>-</i> <b>16. SOCIAL SECURITY NO.</b> <i>-</i> <b>17. INFORMANT</b> <i>Mrs Ruth P. Morelock</i> Address <i>Same</i>				<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <i>Cornary occlusion</i> <b>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST,</b> <b>(b)</b> <i>arteriosclerosis</i> <b>(c)</b> <i>-</i> <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b> <i>-</i>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>-</i>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <i>-</i>							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <i>19</i> p.m. <i>-</i>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <i>-</i>			
<b>20f. (City or town)</b> <i>-</i> <b>(County)</b> <i>-</i> <b>(State)</b> <i>-</i>				<b>21. I certify that (I) (this hospital) attended the deceased from</b> <i>Jan 1, 1966</i> , <b>to</b> <i>Jan 28, 1966</i> , <b>that (I) (we) last saw the deceased alive on</b> <i>Jan 25, 1966</i> , <b>and that death occurred at</b> <i>9 AM</i> , <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <i>E. Reese Wilkens</i> <b>22b. DATE SIGNED</b> <i>Feb 1, 1966</i>				<b>22c. PHYSICIAN'S NAME (Type)</b> <i>E. Reese Wilkens</i> <b>22d. ADDRESS</b> <i>-</i>				<b>22e. ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <i>Burial</i> <b>23b. DATE THEREOF</b> <i>2/3/66</i>				<b>23c. NAME OF CEMETERY OR CREMATORY</b> <i>Kendall Cemetery</i> <b>23d. LOCATION</b> (City, town or county) <i>Rural, Westminster Md.</i>				<b>23e. REC'D BY REGISTRAR</b> <i>-</i> <b>23f. REGISTRAR'S SIGNATURE</b> <i>-</i>			
<b>24. FUNERAL DIRECTOR</b> <i>J. S. Myers, Jr.</i> <b>ADDRESS</b> <i>Westminster, Md.</i>				<b>25a. DATE</b> <i>FEB 3 1966</i>				<b>25b. REGISTRAR'S SIGNATURE</b> <i>-</i>			



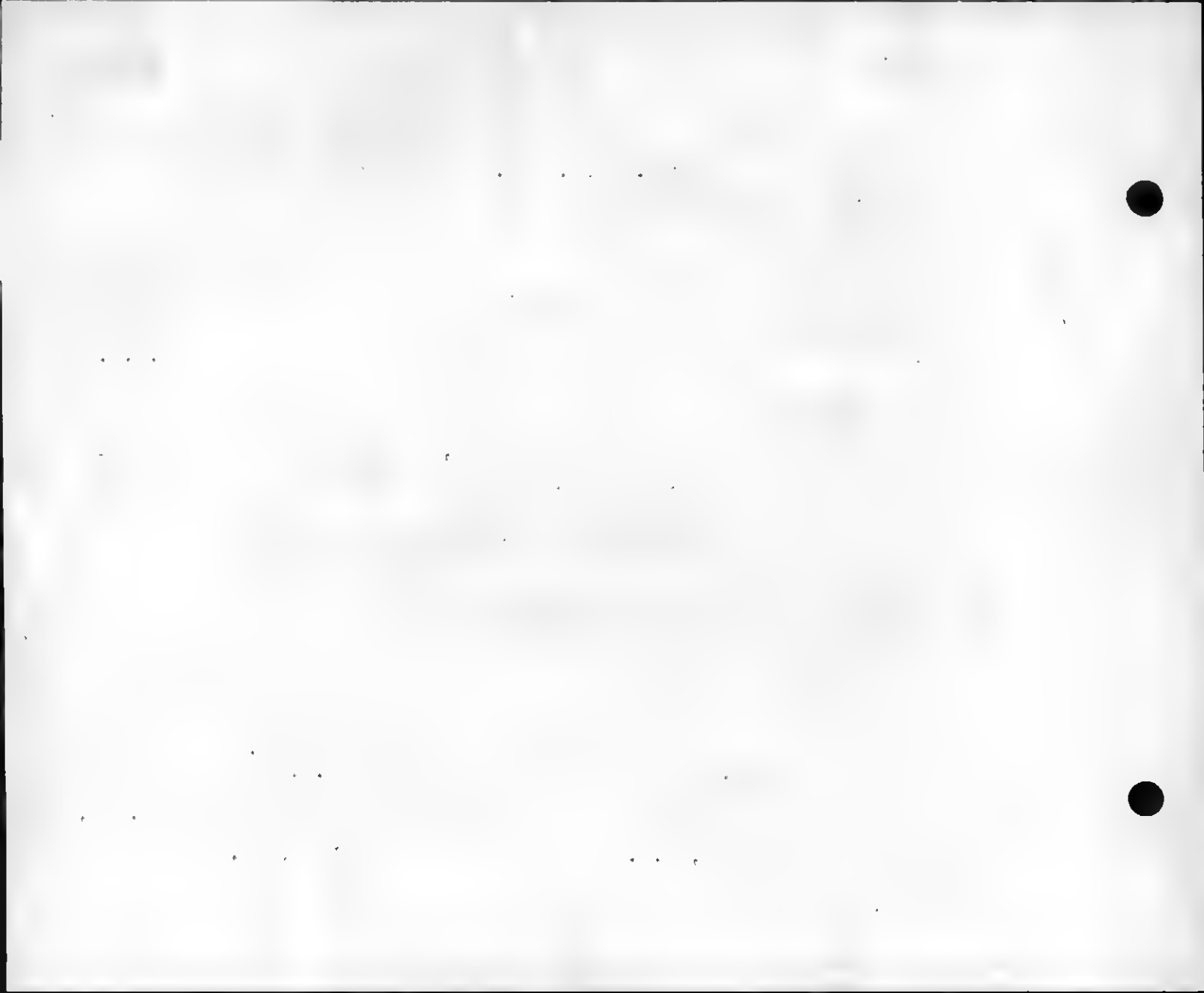
TO HOSPITAL OR ATTENDING PHYSICIAN: The ☒ requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

BP

MEDICAL CERTIFICATION

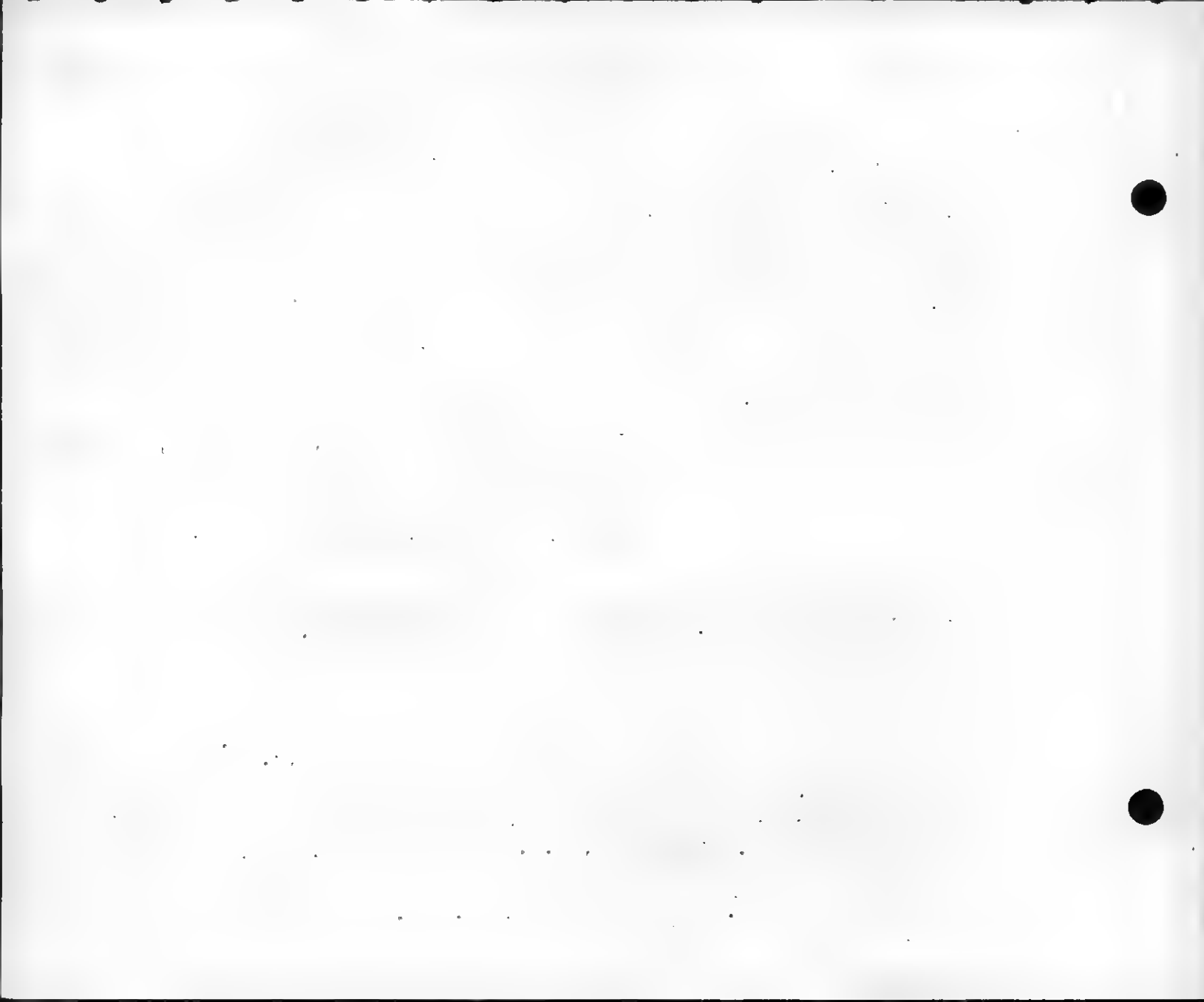
MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
Item #7 Film #6373 2/1/66 pc											
00565											
1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>						c. LENGTH OF STAY IN 1b <b>40yrs. 10mos. 9days</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Springfield State Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>ALICE</b> Middle <b>MORGAN</b> Last <b>ODENSAUS</b>						4. DATE OF DEATH Month <b>JANUARY</b> Day <b>21</b> Year <b>1966</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/5/1887</b> 1879		9. AGE (In years last birthday) <b>86 (?)</b> rs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>(none)</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Morgan</b>						14. MOTHER'S MAIDEN NAME <b>(unknown)</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>(none)</b>		17. INFORMANT Address <b>Records, Springfield State Hospital</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b>										INTERVAL BETWEEN ONSET AND DEATH <b>hours</b>	
4201 DUE TO <b>Arteriosclerotic cardiovascular disease</b>										years	
DUE TO <b>Schizophrenic reaction plus mental retardation</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <del>the</del> (this hospital) attended the deceased from <b>March 12</b> , 19 <b>65</b> , to <b>Jan. 21</b> , 19 <b>66</b> , that <del>it</del> (we) last saw the deceased alive on <b>Jan. 21</b> , 19 <b>66</b> , and that death occurred at <b>1:45 P.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Ilse Kamm</b>						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>Jan. 21, 1966</b>			
22c. PHYSICIAN'S NAME (Type) <b>Ilse Kamm, M.D.</b>						22d. ADDRESS <b>Sykesville, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-22-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Burton Park Cem</b>				23d. LOCATION (City, town or county) (State) <b>Balco 29</b>			
24. FUNERAL DIRECTOR <b>M C Cully Funeral Home</b> ADDRESS <b>2370 Patuxent Ave</b>						25a. REC'D BY REGISTRAR <b>JAN 25 1966</b> DATE		25b. REGISTRAR'S SIGNATURE <b>William Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00566					00556						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY Carroll					a. STATE Maryland						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Sykesville					b. COUNTY Maryland						
c. LENGTH OF STAY IN 1b 7 days					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital					d. STREET ADDRESS 517 Rosehill Terrace						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH			5. AGE (In years last birthday)			6. IF UNDER 1 YEAR		
First Carrie			Middle Lee			Last Palmer			Month 1		
Day 12			Year 19 66			yrs. 95			Months Days Hours Min.		
7. SEX		8. COLOR OR RACE		9. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		10. OATE OF BIRTH		11. AGE (In years last birthday)		12. IF UNDER 24 HRS.	
female		white		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		6/27/72		95		Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)			
housewife								Maryland			
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
USA				David Lowe Worrell				Julia Everheart			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give War or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT			
no				none				Springfield Hospital records, Sykesville			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Cardiac failure											
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (b) Arteriosclerotic cardiovascular disease											
underlying cause last. (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic brain syndrome associated with circulatory disturbance (cerebrovascular accident) with psychotic reaction.											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year				20d. INJURY OCCURRED				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
Hour a.m. p.m. 19				While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20f. (City or town) (County) (State)			
21. I certify that (this hospital) attended the deceased from 1/5/ 1966, to 1/12/ 1966, that (we) last saw the deceased alive on 1/12/ 1966, and that death occurred at 9:30 AM, from the causes and on the date stated above.											
22a. SIGNATURE											
22b. DATE SIGNED											
22c. PHYSICIAN'S NAME (Type) Naci N. Buyukunsal, M.D.											
22d. ADDRESS Springfield State Hospital Sykesville, Maryland											
23a. BURIAL, CREMATION, REMOVAL (Specify)											
23b. DATE THEREOF											
23c. NAME OF CEMETERY OR CREMATORY											
23d. LOCATION (City, town or county) (State)											
24. FUNERAL DIRECTOR											
25a. REC'D BY REGISTRAR											
25b. REGISTRAR'S SIGNATURE											



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VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00567						00557					
1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural--Sykesville</b> c. LENGTH OF STAY IN 1b <b>16 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Springfield State Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> d. STREET ADDRESS <b>15 - 2 5808 Marbury Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>Mildred</b> Middle <b>Susan</b> Last <b>Paul</b>			4. DATE OF DEATH Month <b>1</b> Day <b>16</b> Year <b>1966</b>								
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/21/78</b>		9. AGE (in years last birthday) <b>87</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>25</b> Hours <b>Min.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Missouri</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Richard White</b>						14. MOTHER'S MAIDEN NAME <b>unknown Pegram</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Springfield Hospital records, Sykesville</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> 41-00 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>Bronchopneumonia</b>										INTERVAL BETWEEN ONSET AND DEATH <b>Weeks</b> <b>Years</b> <b>Days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic brain syndrome associated with senile brain disease with psychotic reaction.</b>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <del>70</del> (this hospital) attended the deceased from <b>12/30/</b> , 19 <b>65</b> , to <b>1/16/</b> , 19 <b>66</b> , that <del>if</del> (we) last saw the deceased alive on <b>1/16/</b> 19 <b>66</b> , and that death occurred at <b>8:30 a.m.</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>R. G. Lajonchere MD</b>						22b. DATE SIGNED <b>1/16/66</b>					
22c. PHYSICIAN'S NAME (Type) <b>Rinaldo G. Lajonchere, M.D.</b>						22d. ADDRESS <b>Springfield State Hospital Sykesville, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>1-19-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>			23d. LOCATION (City, town or county) (State) <b>Rockville, Maryland</b>			
24. FUNERAL DIRECTOR <b>Robert C. Rumpkin</b>						25a. REC'D BY REGISTRAR <b>Bethesda Md.</b>		25b. REGISTRAR'S SIGNATURE <b>J. H. St. John</b>			





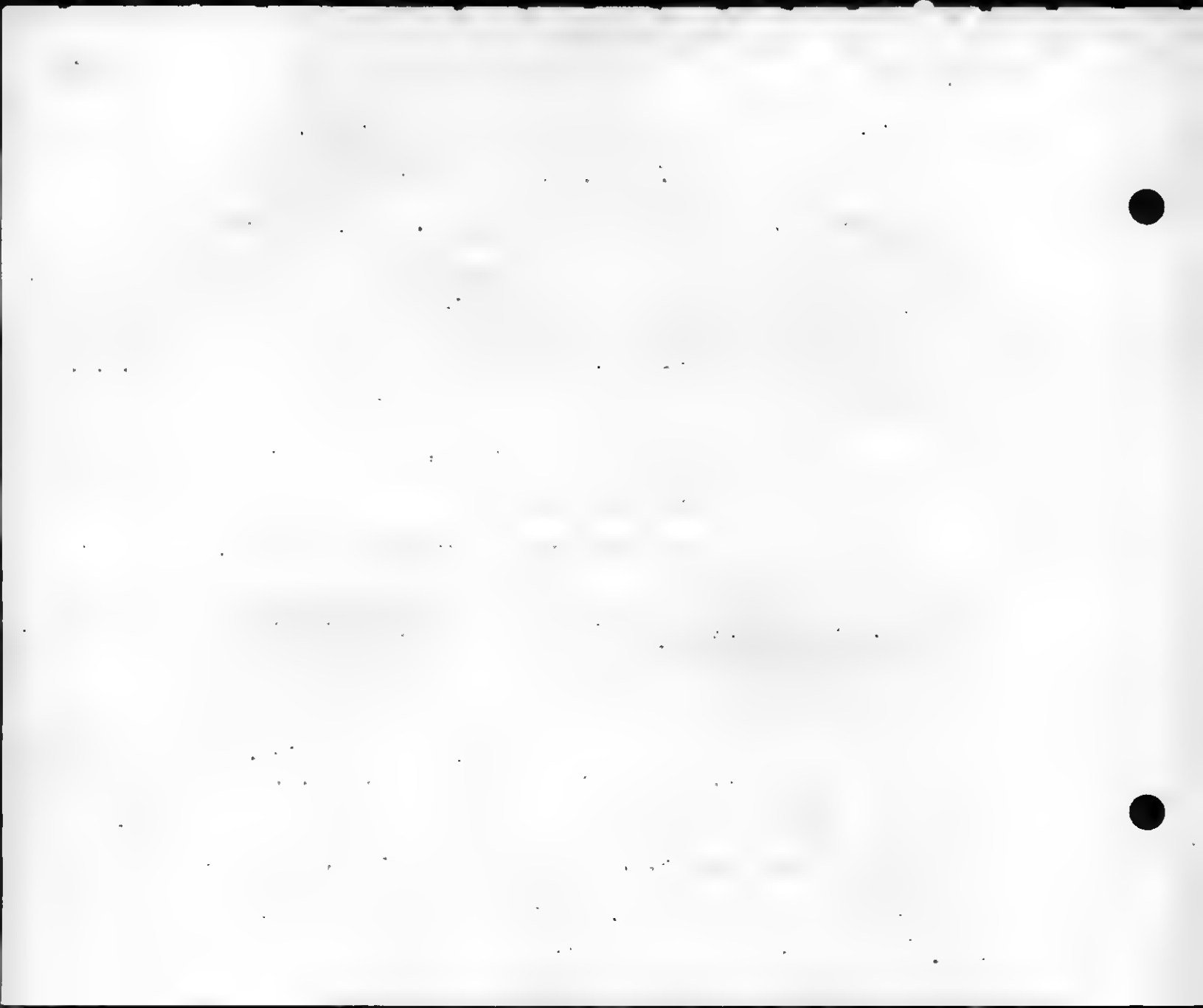
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Carroll</b> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> 4yrs. 10mos. 1day c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Springfield State Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>143 W. Franklin Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) <b>HELEN MARY RAMSEY</b> <b>5. SEX</b> <b>Female</b> <b>6. COLOR OR RACE</b> <b>White</b> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>3-23-90</b> <b>9. AGE</b> (In years) <b>75</b> yrs. <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Nurse</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Nursing</b> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Pennsylvania</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>				<b>4. DATE OF DEATH</b> <b>JANUARY 18 1966</b> <b>13. FATHER'S NAME</b> <b>(unknown)</b> <b>14. MOTHER'S MAIDEN NAME</b> <b>(unknown)</b> <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> <b>16. SOCIAL SECURITY NO.</b> <b>None</b> <b>17. INFORMANT</b> <b>Records, Springfield State Hospital</b> Address							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <b>Bronchopneumonia</b> <b>1221</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <b>Chronic Brain Syndrome associated with senile brain disease with psychotic reaction.</b> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20c. TIME OF INJURY</b> Month, Day, Year <b>19</b> <b>20d. INJURY OCCURRED</b> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)											
<b>21. I certify that (a) (this hospital) attended the deceased from March 17, 1960, to Jan. 18, 1966, that (we) last saw the deceased alive on Jan. 18, 1966, and that death occurred at 2:50 AM on the causes and on the date stated above.</b> <b>22a. SIGNATURE</b> <i>Ilse Kamm</i> <b>M.D.</b> <b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/> <b>22b. DATE SIGNED</b> <b>1-18-66</b> <b>22c. PHYSICIAN'S NAME (Type)</b> <b>Ilse Kamm, M.D.</b> <b>22d. ADDRESS</b> <b>Sykesville, Maryland</b>											
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>23b. DATE THEREOF</b> <b>1-21-66</b> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>St Mary's</b> <b>23d. LOCATION (City, town or county)</b> (State) <b>Hagerstown PA.</b> <b>24. FUNERAL DIRECTOR</b> <b>ADDRESS</b> <b>25a. REC'D BY REGISTRAR</b> <b>25b. REGISTRAR'S SIGNATURE</b> <i>Arthur H. Haight</i> <i>Springfield State Hospital</i> <b>DATE</b> <b>20 1966</b> <i>John Charles Judge</i>											

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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00569

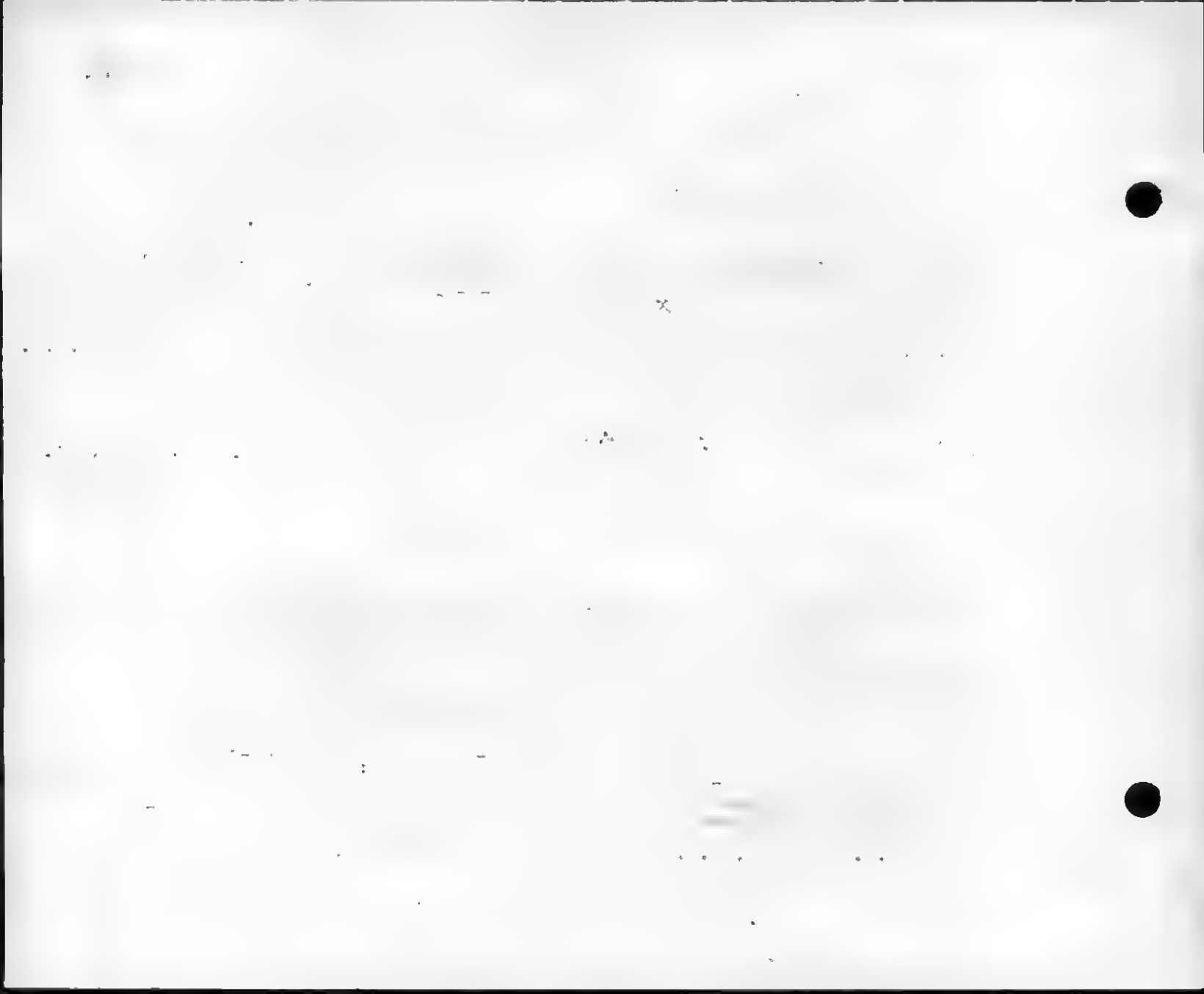
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00559

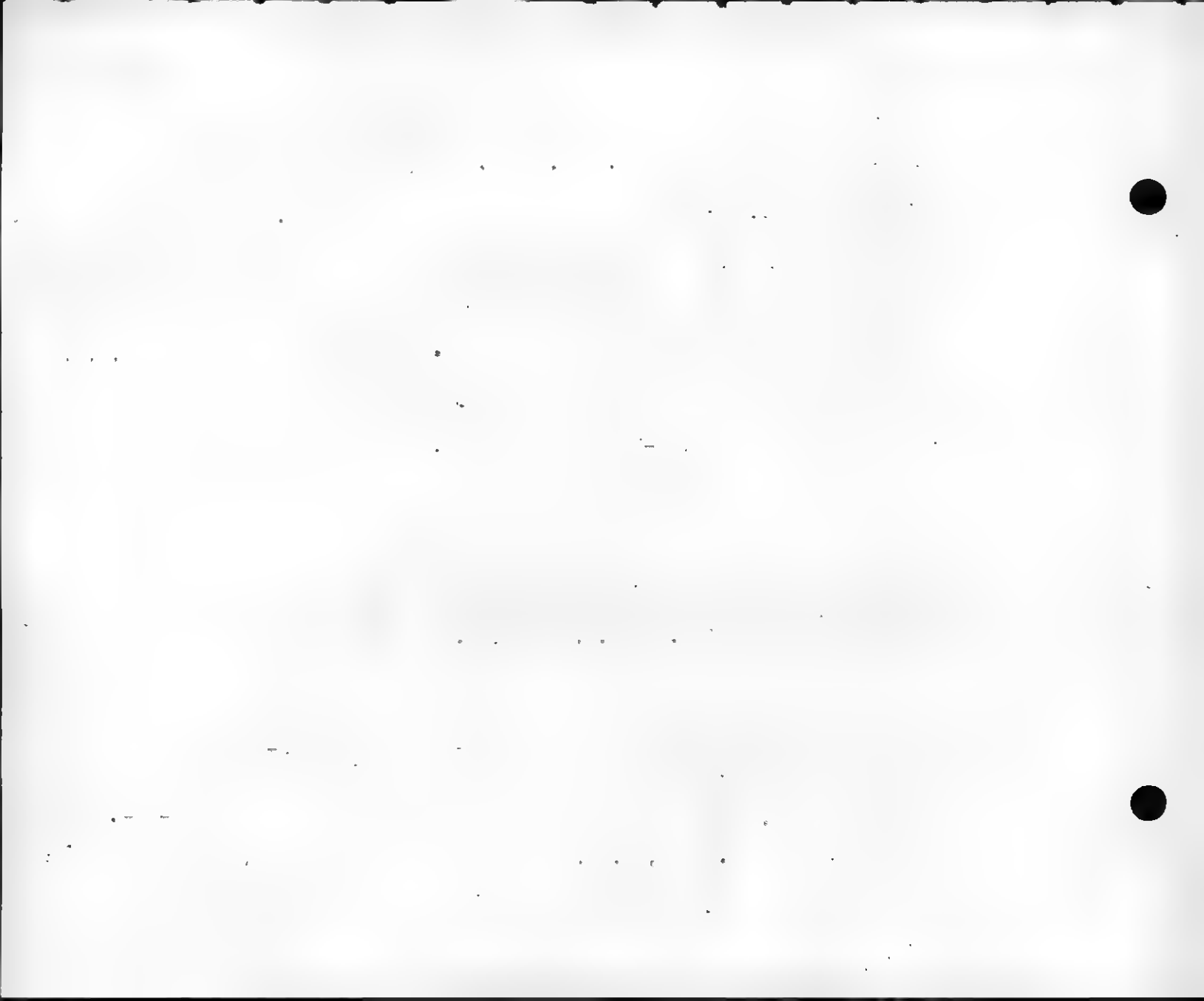
1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>5 MONTH 5</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ANDREW</b> Middle <b>JACKSON</b> Last <b>RAVER</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>1</b> Year <b>19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-1-83</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FARM</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frank Raver</b>		14. MOTHER'S MAIDEN NAME <b>MARY E. ?</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>217-36-4893</b>	
17. INFORMANT <b>Records Springfield Hosp. Sykesville, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BronchoPneumonia</b> <b>71-X</b> DUE TO <b>Infected Decubitus Ulcers</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) _____ DUE TO (c) _____			INTERVAL BETWEEN DEATH AND DEATH <b>Days</b> <b>Weeks</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CBS Associated with senile brain disease with psychotic reaction</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>7-9-65</b> <b>19</b> to <b>1-1-66</b> , <b>19</b> , that (I) (we) last saw the deceased alive on <b>1-1-66</b> , <b>19</b> , and that death occurred at <b>12:05 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>S.P. Wise</b>		22b. DATE SIGNED <b>1-1-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>S.P. Wise M.D.</b>		22d. ADDRESS <b>Sykesville, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>1/4/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>WESTMINSTER, CFM WESTMINSTER MD.</b>	23d. LOCATION (City, town or county) (State)
24. FUNERAL DIRECTOR <b>John G. Saffell Jr.</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>JAN 3 1966</b>	



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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00570					00560				
1. PLACE OF DEATH a. COUNTY <b>Carroll</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>			c. LENGTH OF STAY IN 1b <b>4yrs. 4mos. 13dys.</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			d. STREET ADDRESS <b>3025 Kenyon Ave.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Springfield State Hospital</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>ALVIN</b> Middle <b>ANDREW</b> Last <b>SADLER</b>			4. DATE OF DEATH Month <b>JANUARY</b> Day <b>26</b> Year <b>19 66</b>						
5. SEX <b>Male</b> <b>White</b>		6. COLOR OR RACE <b>White</b> <b>Male</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-8-1897</b>		9. AGE (in years last birthday) <b>68</b> IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Retail</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Anton Sadler</b>					14. MOTHER'S MAIDEN NAME <b>Ida Klarner</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>215-03-9151</b>		17. INFORMANT Address <b>Records, Springfield State Hospital</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Cerebral arteriosclerosis</b> DUE TO (c) <b>Generalized arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CBS with circulatory disturbance other than cerebral arteriosclerosis with psychotic reaction. G.I. bleeding.</b>									INTERVAL BETWEEN ONSET AND DEATH Days  Years  Years
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>9-13-61</b> , 19__ to <b>1-26-66</b> , 19__, that (I) (we) last saw the deceased alive on <b>1-26-66</b> , 19__, and that death occurred at <b>10:00 AM</b> on the causes and on the date stated above.									
22a. SIGNATURE <b>Octavio A. Ruiz</b>					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>1-26-66</b>		
22c. PHYSICIAN'S NAME (Type) <b>Octavio A. Ruiz, M. D.</b>					22d. ADDRESS <b>Springfield State Hospital Sykesville, Maryland</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>Jan 29/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore</b>		
24. FUNERAL DIRECTOR <b>Philip Herwig Sons, Oakland</b>					25a. REC'D BY REGISTRAR <b>DATE FEB 1 1966</b>				
25b. REGISTRAR'S SIGNATURE <b>John J. Page</b>									



TO HOSPITAL: 3 ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00571

Item #9 Film #G373 2/4/66 ps

00561

1. PLACE OF DEATH a. COUNTY <u>Carroll</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodbine</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodbine</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Golden Age Sweet Home</u>		d. STREET ADDRESS <u>6429 Cedonia Avenue #6</u>	
3. NAME OF DECEASED (Type or print) <u>Caroline Elizabeth Schmidt</u>		4. DATE OF DEATH <u>Jan 26 1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-17-1891</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
13. FATHER'S NAME <u>George Easter</u>		14. MOTHER'S MAIDEN NAME <u>Caroline Seckle</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-34-6873</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>332 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Arteriosclerosis</u> <u>Card. Disturbance</u> <u>Hypertension</u>		17. INFORMANT <u>Mr Henry Schmidt 1911 Leyden Road Timonium</u> Address <u>Timonium</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 22 1963</u> to <u>Jan 26 1966</u> that (I) (we) last saw the deceased alive on <u>Jan 26 1966</u> and that death occurred <u>3:30 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>N N MASTIN</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>N N MASTIN</u>		22d. ADDRESS <u>55 Penna Ave Westernville Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-29-1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Western Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore City Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home 2401 Belair Road (36)</u>		25a. REC'D BY REGISTRAR <u>FEB 1 1966</u> 25b. REGISTRAR'S SIGNATURE <u>W. H. Jones</u>	



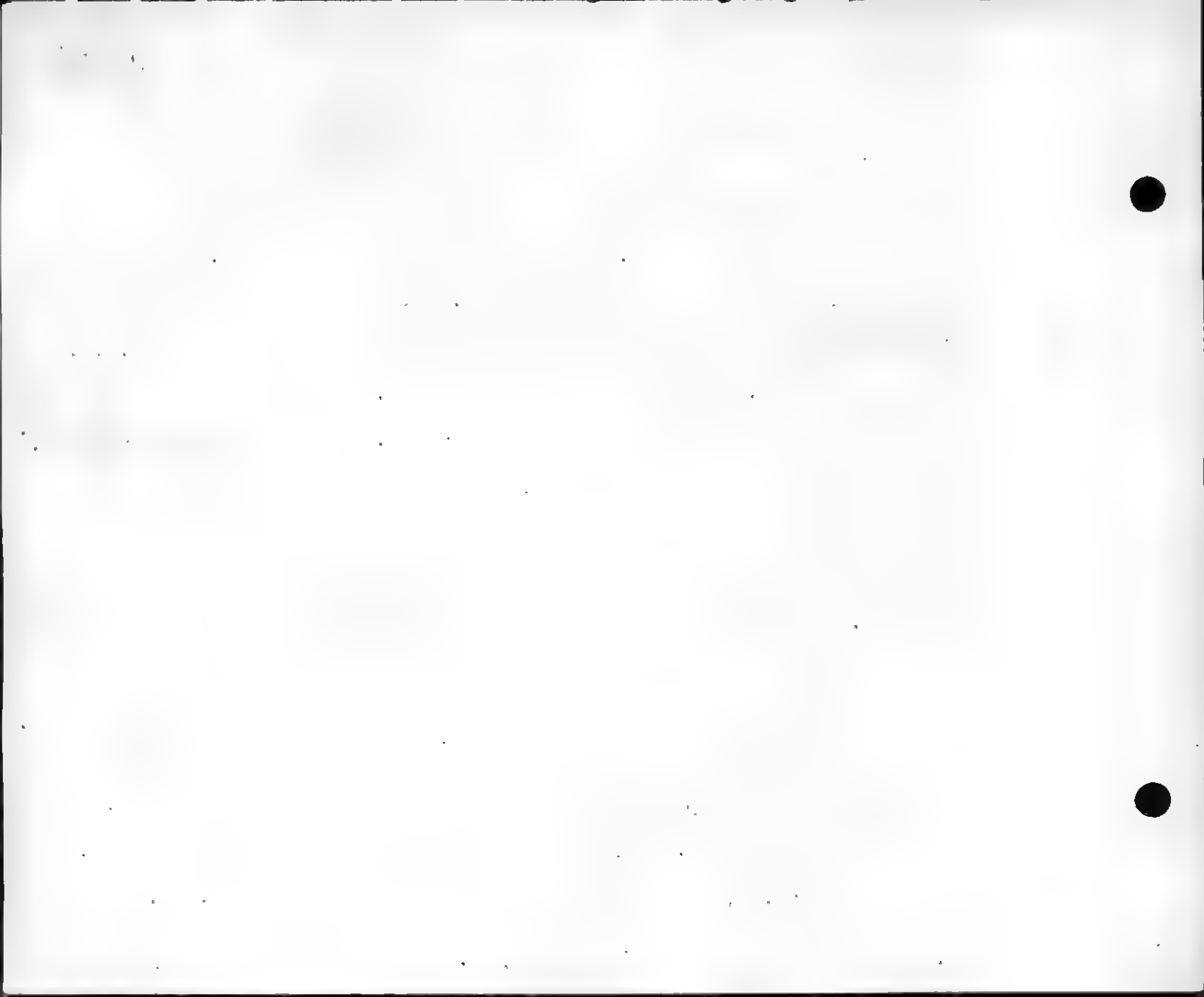


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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00572 CERTIFICATE OF DEATH 00562

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Westminster</b> c. LENGTH OF STAY IN 1b <b>2 weeks</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Carroll County General Hospital</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Westminster</b> d. STREET ADDRESS <b>14 Webster Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>AGNES</b> Middle <b>B.</b> Last <b>SCHWEIGART</b>				4. DATE OF DEATH Month <b>Jan.</b> Day <b>1,</b> Year <b>1966</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 18, 1882</b>	
9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months <b>8</b> Days <b>3</b> Hours <b>0</b> Min.		11. BIRTHPLACE (County & State, or foreign country) <b>Carroll County, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		13. FATHER'S NAME <b>William H. Bankert</b>	
14. MOTHER'S MAIDEN NAME <b>Annie R. Reigle</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>--</b>		16. SOCIAL SECURITY NO. <b>--</b>	
17. INFORMANT <b>Monais V. Bankert</b>				Address <b>414 Spring St. Martinsburg, Pa.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> 1200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral vascular insufficiency</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.			
20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <b>Dec 20, 1965</b> to <b>Jan 1, 1966</b> , that (I) (we) last saw the deceased alive on <b>Jan 1, 1966</b> , and that death occurred at <b>7 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>John S. Harshey</b> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <b>1/1/66</b>			
22c. PHYSICIAN'S NAME (Type) <b>JOHN S. HARSHEY, M.D.</b>				22d. ADDRESS <b>8 Archer St. Westminster, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>				23b. DATE THEREOF <b>Jan. 4, 1966</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>Westminster Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>Westminster, Md.</b>			
24. FUNERAL DIRECTOR <b>J. E. Myers, Jr., Westminster, Md.</b>				25a. REC'D BY REGISTRAR <b>JAN 5 1966</b>			
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>							



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

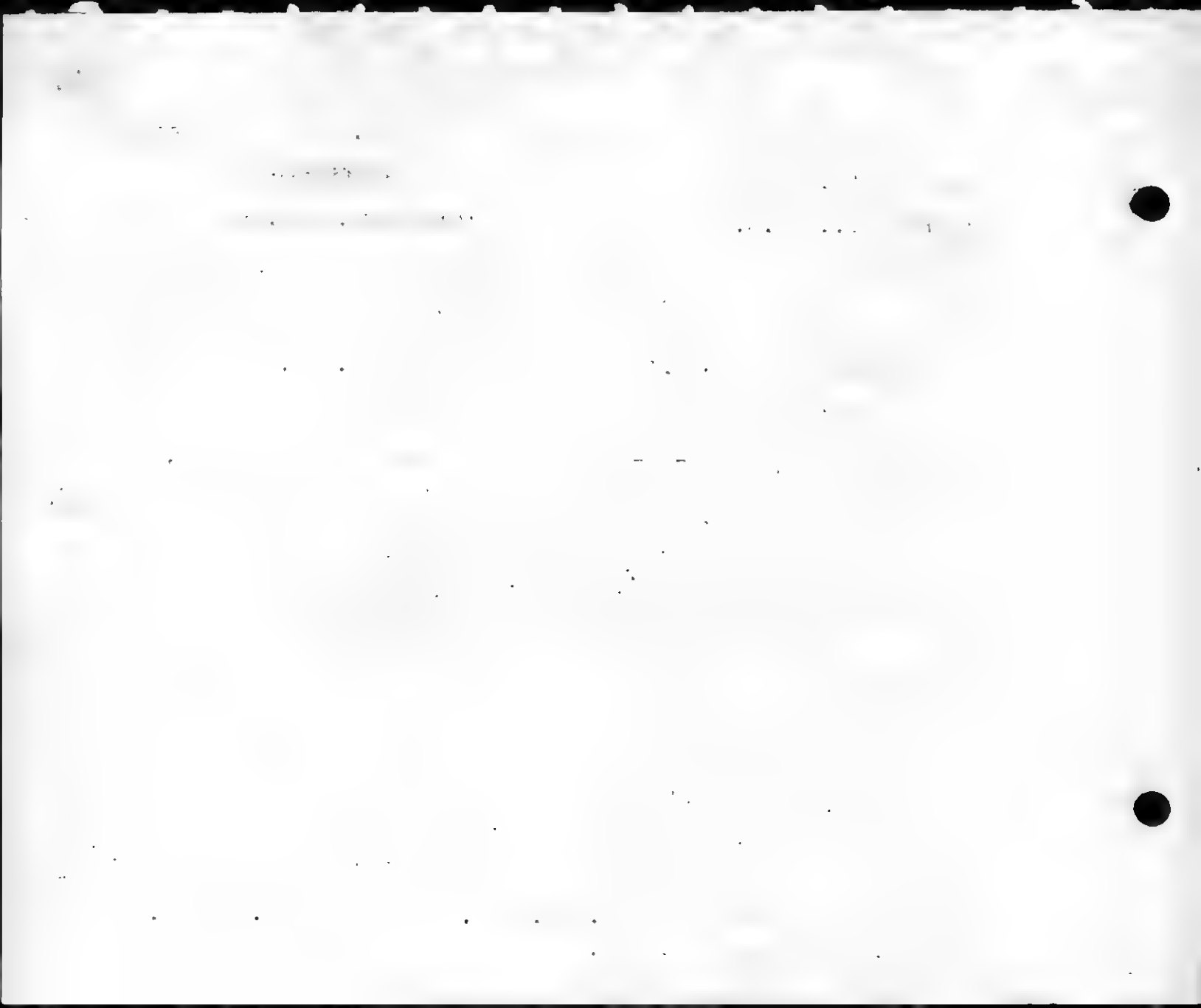
00573

00563

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Westminster</b> c. LENGTH OF STAY IN b. <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Strand Ave., Rt. 5.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Carroll</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>3121 Pelham Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>ALFRED</b> Last <b>SHEPPARD</b>		4. DATE OF DEATH Month <b>January</b> Day <b>31</b> Year <b>1966</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/8/1890</b>
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR: Months <b>7</b> Days <b>15</b> Hours <b>15</b> Min. <b>15</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Geo. Franke &amp; Sons Balto. Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Charles Sheppard</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>215-09-2115</b>	
17. INFORMANT <b>Ruth Smoot Sheppard, wife, above</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis (acute)</b> DUE TO (b) <b>Hypertension</b> DUE TO (c) <b>Arteriosclerosis</b> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>15 yrs.</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Alfred Sheppard</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/4/66</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Balto. Nat. Cem.</b>		22d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc. 3331 Brehms Lane</b>		24. REC'D BY REGISTRAR <b>2 1966</b>	
ADDRESS		25. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00574					00564						
1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> c. LENGTH OF STAY IN 1b <b>3mos. 12dys.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>2216 Garrison Blvd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last <b>NELSON ROGER SHOWACRE</b>			4. DATE OF DEATH Month Day Year <b>JANUARY 28 19 66</b>								
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-18-06</b>		9. AGE (In years last birthday) <b>59</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shop worker/radio repairman</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Nelson Showacre</b>					14. MOTHER'S MAIDEN NAME <b>Elma D. Schneidereith</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Records, Springfield State Hospital</b>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia, organism undetermined</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Multiple gangrenous infected decubitus ulcers</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH Days  Weeks	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <b>10-16-65</b> <b>19</b> to <b>1-28-66</b> <b>19</b> , that (I) (we) last saw the deceased alive on <b>1-28-66</b> <b>19</b> , and that death occurred at <b>3:35 AM</b> M, from the causes and on the date stated above.											
22a. SIGNATURE <i>Octavio A. Ruiz</i>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>1-28-66</b>				
22c. PHYSICIAN'S NAME (Type) <b>Octavio A. Ruiz, M.D.</b>					22d. ADDRESS <b>Springfield State Hospital Sykesville, Maryland</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>1/31/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>		23d. LOCATION (City, town or county) (State) <b>Pikeville, Maryland</b>				
24. FUNERAL DIRECTOR <b>Wm J. Sicker &amp; Sons</b>					ADDRESS <b>Baltimore, Md.</b>		25a. REC'D BY REGISTRAR <b>FEB 1 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Carroll</b> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Westminster</b> c. LENGTH OF STAY IN 1b <b>53 yrs</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>61 Westmoreland Street</b>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Westminster</b> d. STREET ADDRESS <b>61 Westmoreland Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) <b>ELIZABETH ANN SNADER</b>			<b>4. DATE OF DEATH</b> <b>January 9, 1966</b>			<b>5. SEX</b> <b>female</b>			<b>6. COLOR OR RACE</b> <b>white</b>		
<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>			<b>8. DATE OF BIRTH</b> <b>May 26, 1865</b>			<b>9. AGE</b> (in years last birthday) <b>100 yrs.</b>			<b>IF UNDER 1 YEAR</b> Months <input type="checkbox"/> Days <input type="checkbox"/> <b>IF UNDER 24 HRS.</b> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>housewife</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Carroll Co., Maryland</b>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>				<b>13. FATHER'S NAME</b> <b>John Royer</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Elizabeth Geiman</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown)				<b>16. SOCIAL SECURITY NO.</b>				<b>17. INFORMANT</b> <b>Miss Edith R. Snader</b> Address <b>same</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia Broncho</b> (b) <b>Chronic Myocarditis (Heart block)</b> (c) <b>Arteriosclerosis + Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>2 wks</b> <b>General</b> <b>4 yrs</b> <b>General</b> <b>4 yrs</b>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>											
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. 19 p.m.				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from May 11, 1963, to June 19, 1966, that (I) (we) last saw the deceased alive on June 19, 1966, and that death occurred at 7:30 AM from the causes and on the date stated above.</b>											
<b>22a. SIGNATURE</b> <i>W. L. Speiker</i> M.D.						<b>22b. DATE SIGNED</b> <b>1-10-66</b>			<b>22c. PHYSICIAN'S NAME</b> (Type) <b>Westminster Md</b>		
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>burial</b>				<b>23b. DATE THEREOF</b> <b>1/12/66</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Meadow Branch Cemetery</b>				<b>23d. LOCATION</b> (City, town or county) (State) <b>nr Westminster, Maryland</b>	
<b>24. FUNERAL DIRECTOR</b> <b>J. Z. Myer, Jr. Westminster, Md</b> ADDRESS						<b>25a. REC'D BY REGISTRAR</b> <b>J. Charles Judge</b>			<b>25b. REGISTRAR'S SIGNATURE</b>		
<b>DATE</b> <b>JAN 12 1966</b>											

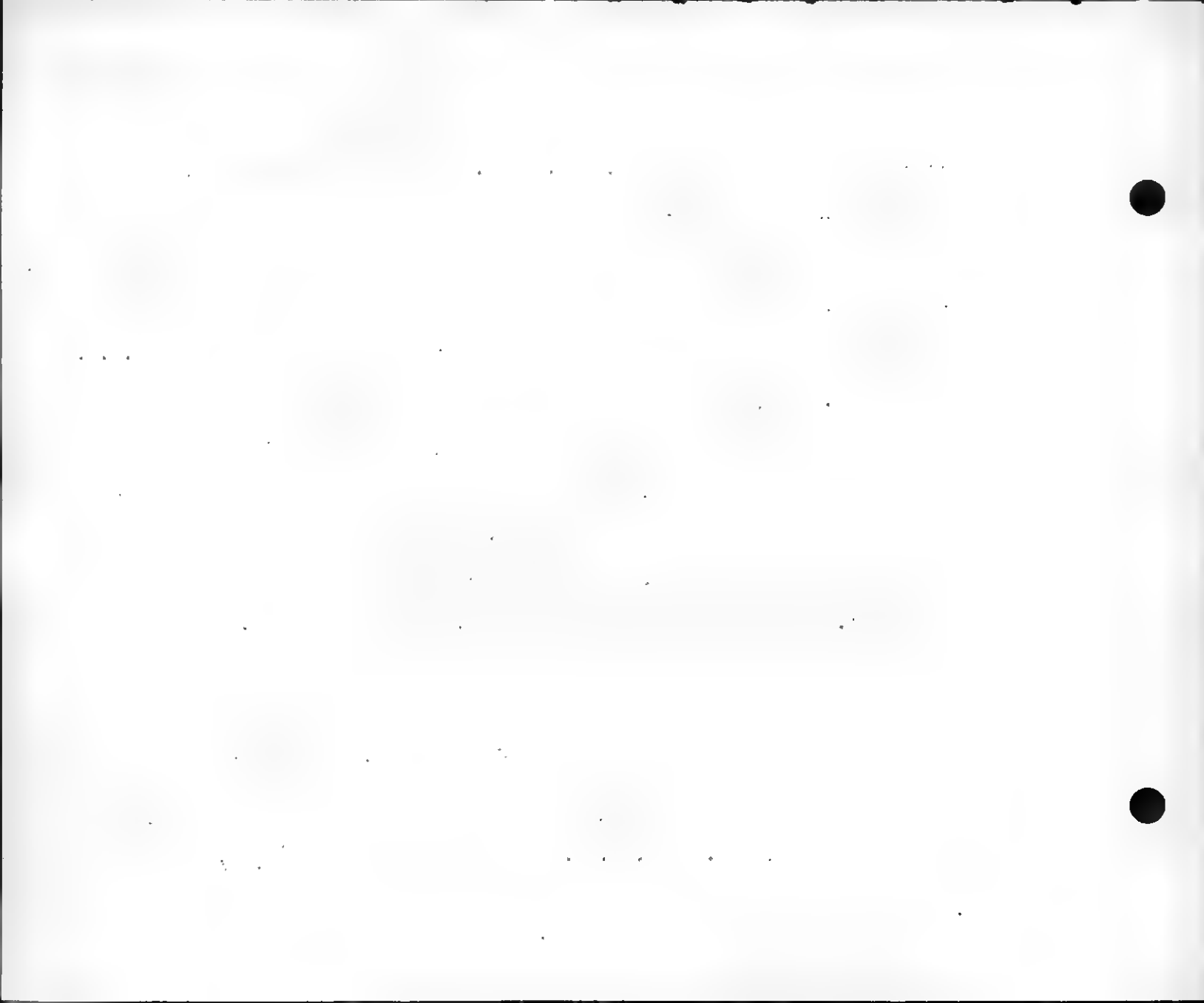




TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00576					00566				
1. PLACE OF DEATH a. COUNTY <b>Carroll</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>			c. LENGTH OF STAY IN 1b <b>9yrs. 9mos. 11dys.</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural - Westminster Md # 6.6.1</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Springfield State Hospital</b>					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>WILLIAM</b> Last <b>SPENCER</b>			4. DATE OF DEATH Month <b>JANUARY</b> Day <b>17</b> Year <b>19 66</b>						
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-27-1885</b>		9. AGE (In years last birthday) <b>80</b> IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pipe fitter</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Remo. Railroad</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James P. Spencer</b>					14. MOTHER'S MAIDEN NAME <b>Mary Evans</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Records, Springfield State Hospital</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>4200</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>Generalized arteriosclerosis</b>								INTERVAL BETWEEN ONSET AND DEATH <b>Days</b>  <b>Years</b>  <b>Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>CBS assoc. with cerebral arteriosclerosis, without qualifying phase</b>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <input type="checkbox"/> <b>p.m.</b> <input type="checkbox"/> <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>4-6-56</b> , 19____, to <b>1-17-66</b> , 19____, that (I) (we) last saw the deceased alive on <b>1-17-66</b> , 19____, and that death occurred at <b>9:45 AM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Octavio A. Ruiz</b>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>1-17-66</b>		
22c. PHYSICIAN'S NAME (Type) <b>Octavio A. Ruiz, M. D.</b>					22d. ADDRESS <b>Springfield State Hospital Sykesville, Maryland</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		23b. DATE THEREOF <b>1/20/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St Marys Prot. Episcopal Cemetery Hampden Baltimore Md.</b>		23d. LOCATION (City, town or county) (State)			
24. FUNERAL DIRECTOR <b>J. E. Myers Jr. Westminster Md</b>					25a. REC'D BY REGISTRAR <b>JAN 19 1966</b>				
					25b. REGISTRAR'S SIGNATURE				



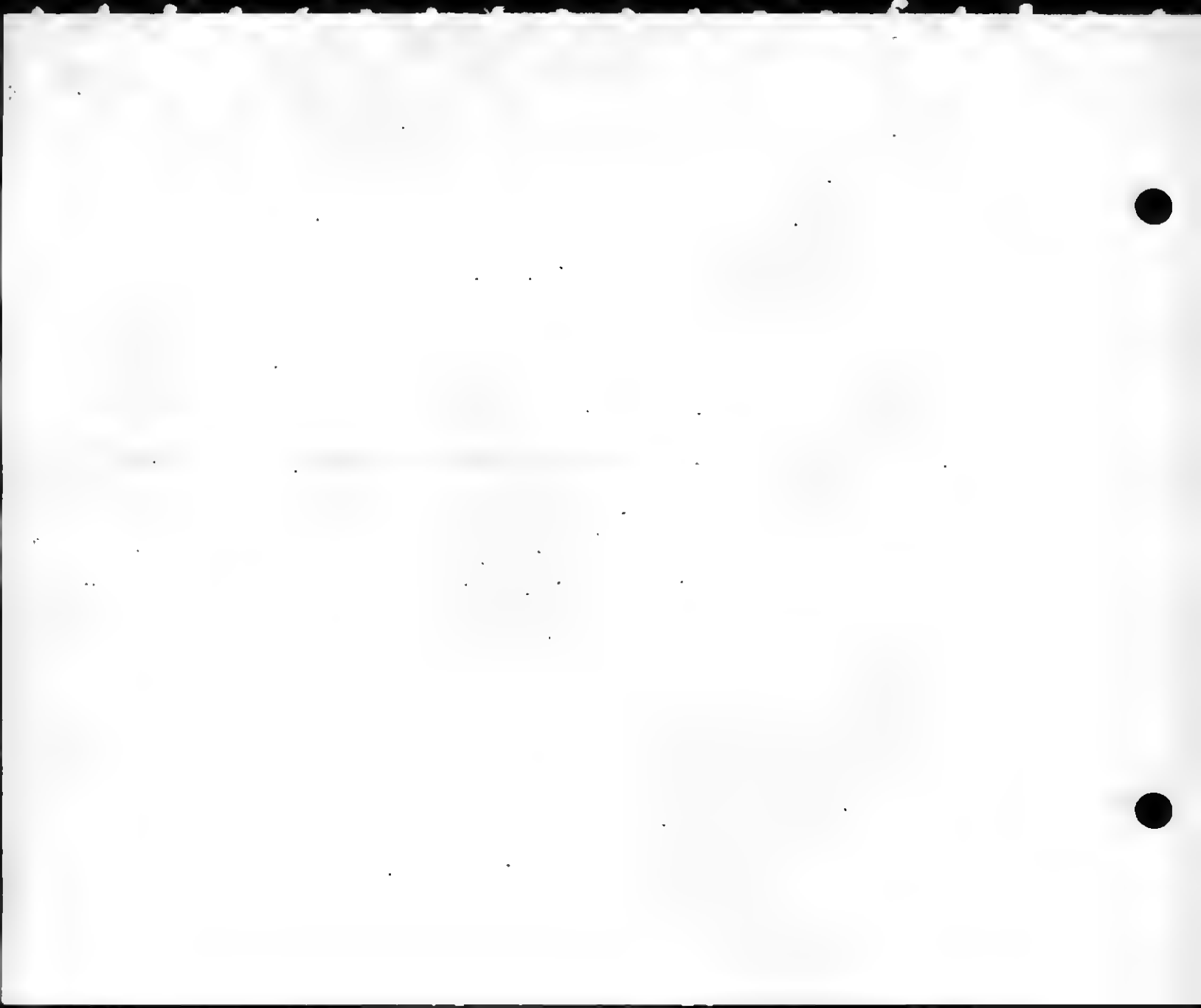
1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00577		00567	
1. PLACE OF DEATH a. COUNTY CARROLL COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL WESTMINSTER		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL WESTMINSTER, MD	
c. LENGTH OF STAY IN 1b 9 YRS.		d. STREET ADDRESS RD #7 OLD TANEYTOWN ROAD	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) OLD TANEYTOWN ROAD		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last PAUL BRUCE STARNER		4. DATE OF DEATH Month Day Year JAN. 18 19 66	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB 25 1889 76
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARM	
11. BIRTHPLACE (State or foreign country) CARROLL COUNTY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JACOB D. STARNER		14. MOTHER'S MAIDEN NAME JESSIE BELLE DAYHOFF	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 220-34-5740	
17. INFORMANT Address RD 1 SON DAVID STARNER WESTMINSTER, MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X Coronary Thrombosis (acute) 2 hrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) Atherosclerotic Myocardial Infarction (united) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 hrs 2 hrs 2 hrs 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE W. GLENN SPEICHER		22. DATE SIGNED 11-18-66	
EXAMINER'S NAME (Type) W. GLENN SPEICHER		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, City, Town, or County) Westminster, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 1/21/66	23c. NAME OF CEMETERY OR CREMATORY KRIDERS CEMETERY WESTMINSTER, MD.	23d. LOCATION (City, town or county) (State) Westminster, MD
24. FUNERAL DIRECTOR James C. Saffell		25a. REC'D BY REGISTRAR JAN 20 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

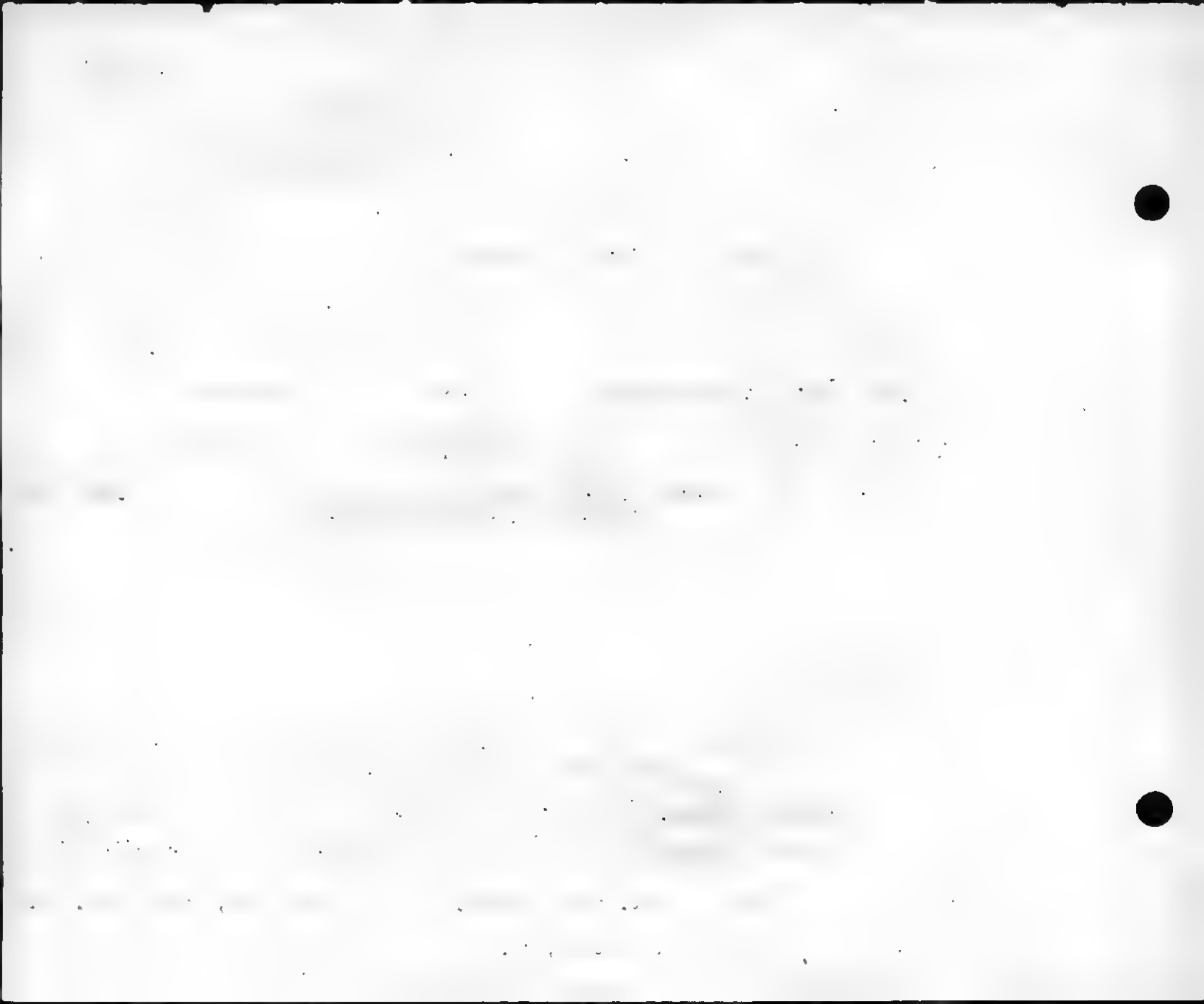


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal after any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>											
<b>00578</b> 1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER RUN</u> c. LENGTH OF STAY IN 1b <u>8 YRS.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WESTMINSTER, MD. RDI (SILVER RUN)</u>				<b>00568</b> 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER, MD. RDI (SILVER RUN)</u> d. STREET ADDRESS <u>RDI.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>DONALD</u> Middle <u>LEE</u> Last <u>STONESIFER</u>				4. DATE OF DEATH Month <u>1</u> Day <u>20</u> Year <u>1966</u>							
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/17/57</u>		9. AGE (In years last birthday) <u>8</u> yrs. IF UNDER 1 YEAR: Months <u>8</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CHILD</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>GETTYSBURG, PA.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		
13. FATHER'S NAME <u>CARL DAVID STONESIFER</u>						14. MOTHER'S MAIDEN NAME <u>CAROLE ECKARD</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>PARENTS.</u> Address <u>(ABOVE)</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRAIN STEM TUMOR.</u> <u>71</u> DUE TO <u>(TYPE UNDETERMINED.)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____										INTERVAL BETWEEN ONSET AND DEATH <u>DEC 1964</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>12/2</u> , 19 <u>64</u> , to <u>1/20</u> , 19 <u>66</u> , that (I) <u>last</u> saw the deceased alive on <u>1/20 1966</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>John A. Grant</u>						22b. DATE SIGNED <u>1/20/66</u>					
22c. PHYSICIAN'S NAME (Type) <u>JOHN A. GRANT</u>						22d. ADDRESS <u>22 W. CHESTNUT ST. HANOVER, PA.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>1/22/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Marys Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Silver Run, Carroll Co. Md.</u>			
24. FUNERAL DIRECTOR <u>Richard A. Little</u> ADDRESS <u>Littlestown, Pa.</u>						25a. REC'D BY REGISTRAR <u>JAN 24 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
00579					00569					
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b		a. STATE		b. COUNTY	
Carroll		Sykesville			13 Yrs. 8Mo.		Maryland		Washington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS					e. IS RESIDENCE ON A FARM?
Springfield State Hospital					245 East Howard St.					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)			First		Middle		Last		4. DATE OF DEATH	
Helen May Swartz									Month Day Year	
5. SEX	6. COLOR OR RACE	7. MARRIED	NEVER MARRIED	8. DATE OF BIRTH	9. AGE (in years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days	Hours
Female	White	WIDOWED	DIVORCED	3-11-1910	55 yrs.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
None						Virginia		U.S.A.		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME					Address
James Swartz					Mabel ?					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT					
No			None		Hospital Records					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b>										Day
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO		Possible septicemia due to large gangrenous,					Weeks
			(b)		infected, decubitus ulcers					
			DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED?
										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year			20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
Hour a.m. p.m.			While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>							
21. I certify that (I) (this hospital) attended the deceased from 5-15 1966 to 1-30 1966, that (I) (we) last saw the deceased alive on 1-30 1966, and that death occurred at 3 PM, from the causes and on the date stated above.										
22a. SIGNATURE					22b. DATE SIGNED					
R. G. Lajonchere M.D.					1-30-66					
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS					
Dr Lajonchere M.D.					Sykesville, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county)		(State)		
Burial		2/3/66		Rose Hill Cemetery		Hagerstown		Md.		
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Rest Haven Funeral Chapel Hagerstown, Md.					FEB 4 1966		J. Charles Judge			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

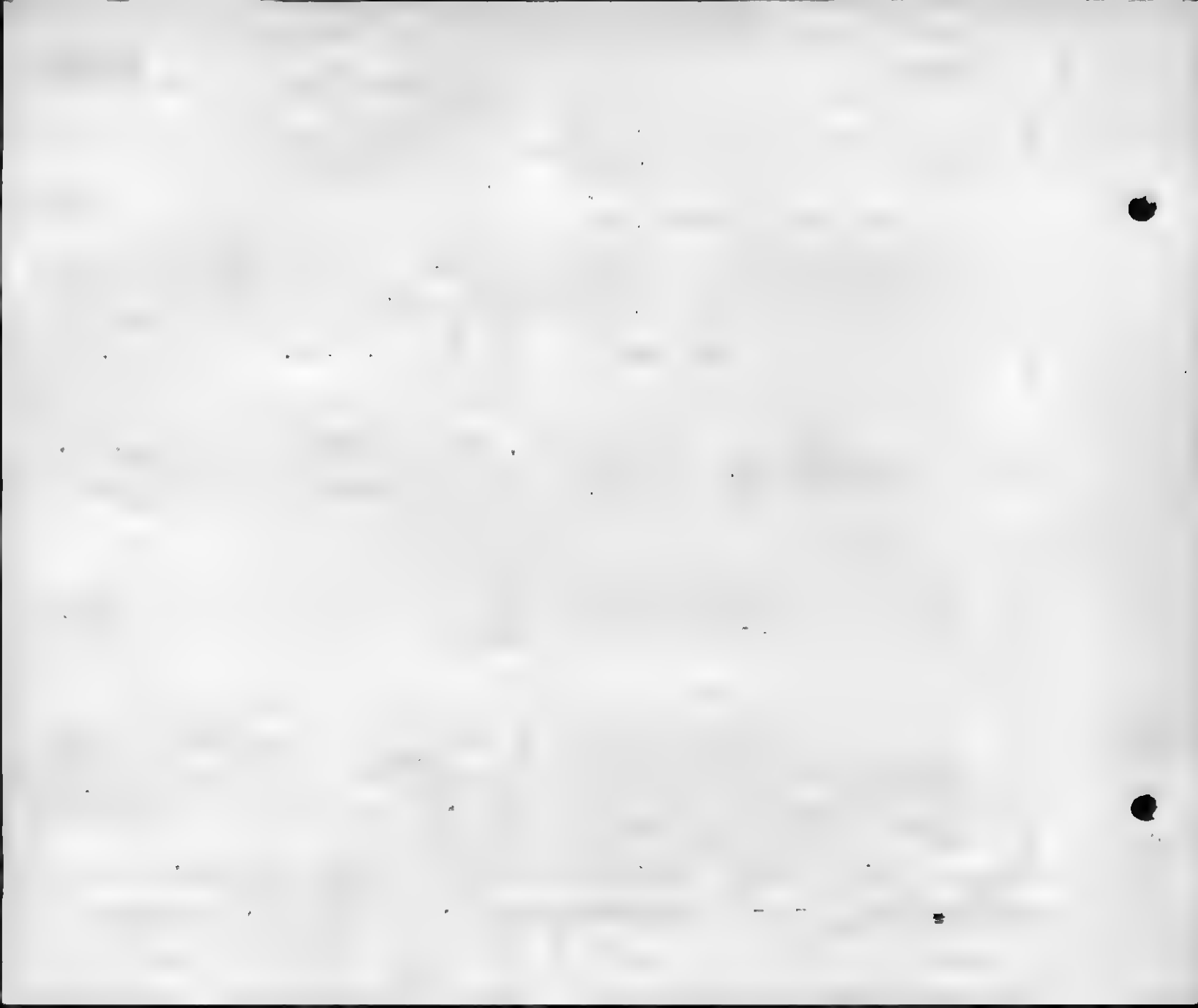
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00580

00570

1. PLACE OF DEATH a. COUNTY <b>CARROLL</b>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CARROLL</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MIDDLEBURG</b>			c. LENGTH OF STAY IN 1b <b>APPROXIMATELY 3 MONTHS</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>BROOKFIELD MANOR NURSING HOME</b>			d. STREET ADDRESS <b>ROUTE 2</b>		
3. NAME OF DECEASED (Type or print) <b>NANCY JANE TESTERMAN</b>			4. DATE OF DEATH Month Day Year <b>JANUARY 28, 19 66</b>		
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED XX</b> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 1, 1867</b>		9. AGE (In years last birthday) <b>98</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	11. BIRTHPLACE (County & State, or foreign country) <b>ASH COUNTY, N. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>JUNIOR MOCK</b>			14. MOTHER'S MAIDEN NAME <b>KATHERINE MOCK</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO NONE</b>		16. SOCIAL SECURITY NO <b>NONE</b>	17. INFORMANT <b>MRS. CORDIE TESTERMAN, STERLING, VA.</b> Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Atherosclerosis</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <b>Left Lower Lobe pneumonia</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Left Lower Lobe pneumonia</b>					INTERVAL BETWEEN ONSET AND DEATH <b>years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>5/10/59</b> to <b>1/28/66</b> , that (I) <b>OWN</b> last saw the deceased alive on <b>1/28/66</b> , and that death occurred on <b>1/28/66</b> at <b>8:30</b> M, from the causes and on the date stated above					
22a. SIGNATURE <b>J. H. Caricofe</b>		M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) <b>J. H. CARICOFE</b>		22d. ADDRESS <b>UNION BRIDGE, MARYLAND.</b>		22e. DATE SIGNED <b>1/28/66</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL-BURIAL</b>		23b. DATE THEREOF <b>1-31-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>STERLING CEMETERY,</b>		23d. LOCATION (City, town or county) (State) <b>STERLING, VIRGINIA</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. Berkeley Green, Herndon, Va.</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>FEB 7 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

**MARYLAND STATE DEPARTMENT OF HEALTH**

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

00581

00571

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>2yrs. 8mos. 29dys.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Springfield State Hospital</b>				e. STREET ADDRESS <b>1403 W. Mosher St.</b>			
3. NAME OF DECEASED (Type or print) First <b>LORREY (LLOYD)</b> Middle <b>JAMES</b> Last <b>THOMPSON</b>				4. DATE OF DEATH Month <b>JANUARY</b> Day <b>27</b> Year <b>19 66</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4-4-03</b>	
9. AGE (In years last birthday) <b>62</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bartender</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Thompson</b>				14. MOTHER'S MAIDEN NAME <b>Nanie Talbott</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>Unk.</b>		17. INFORMANT <b>Records, Springfield State Hospital</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Severe coronary arteriosclerosis.</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CBS assoc. with CNS syphilis, meningovascular, without qualifying phrase</b>							INTERVAL BETWEEN ONSET AND DEATH <b>mins. / hrs.</b> <b>years</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>W. Glenn Spelcher</i> EXAMINER'S NAME (Type) <b>W. Glenn Spelcher, M. D.</b>				22. DATE SIGNED <b>1-27-66</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/5/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Balto. Md.</b>	
24. FUNERAL DIRECTOR <i>W. L. Mark</i> ADDRESS <b>9288 N. ...</b>				25. REC'D BY REGISTRAR DATE <b>18 4 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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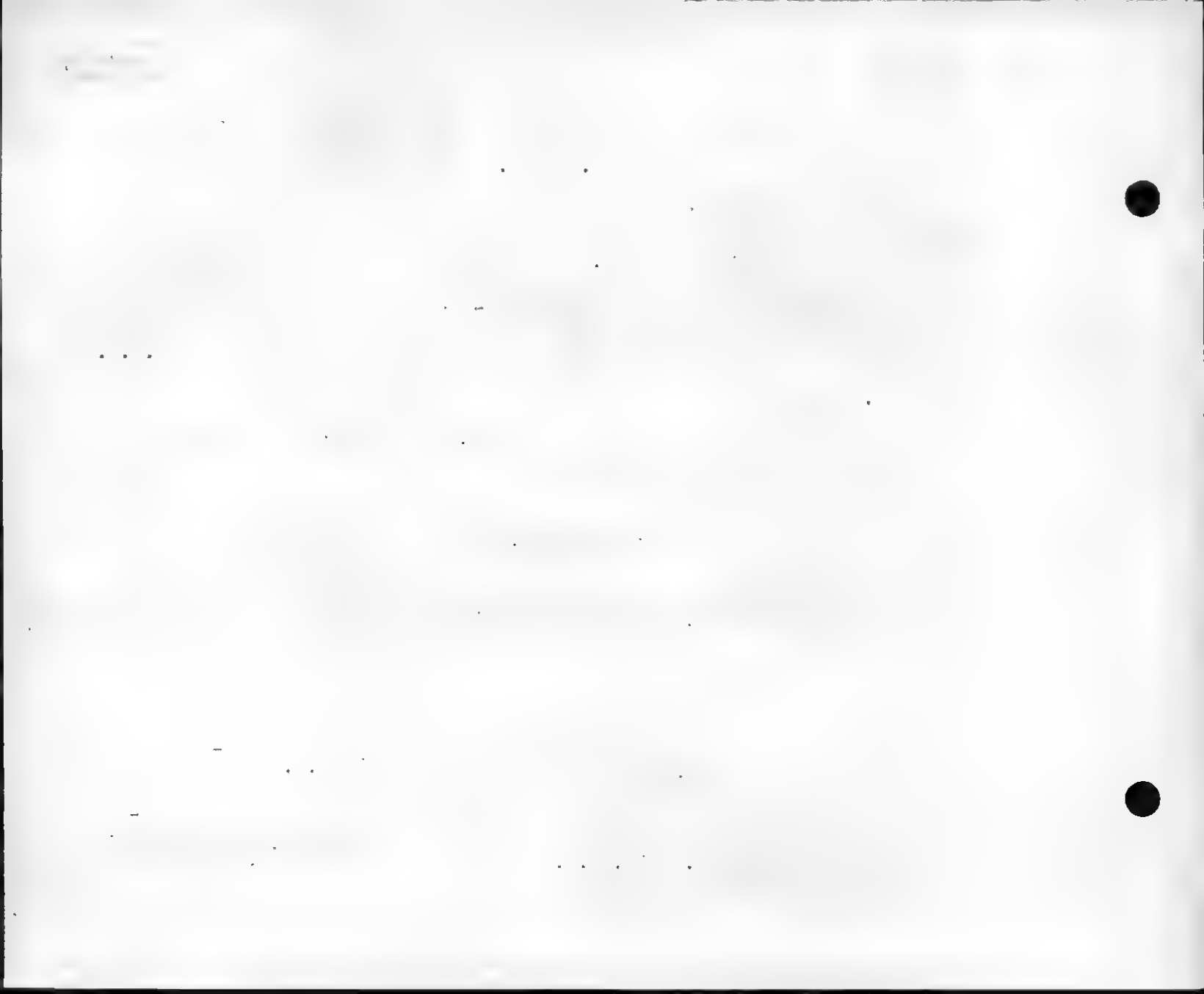
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

00582

00572

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>32 yrs. 9 dys.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>				e. STREET ADDRESS <b>813 Lanvale Street</b>			
3. NAME OF DECEASED (Type or print) First <b>JOEL</b> Middle <b>K.</b> Last <b>TICE</b>				4. DATE OF DEATH Month <b>January</b> Day <b>18</b> Year <b>19 66</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-24-89</b>	
9. AGE (in years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm hand</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>David M. Tice</b>				14. MOTHER'S MAIDEN NAME <b>Margaret O'Keefe</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Records, Springfield State Hospital</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO (b) <b>Chronic pyelonephritis</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <b>days</b>  <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Schizophrenic reaction, other and unspecified</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1-9-34</b> to <b>1-18-66</b> , that (I) (we) last saw the deceased alive on <b>1-18-66</b> , and that death occurred at <b>7:15 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <i>Octavio A. Ruiz</i>				22b. DATE SIGNED <b>1-18-66</b>			
22c. PHYSICIAN'S NAME (Type) <b>Octavio A. Ruiz, M.D.</b>				22d. ADDRESS <b>Springfield State Hospital Sykesville, Maryland 21784</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>JAN. 20</b>		23c. NAME OF CEMETERY OR CREMATORY <b>RIVERVIEW</b>		23d. LOCATION (City, town or county) (State) <b>WILLIAMSPORT MD</b>	
24. FUNERAL DIRECTOR <i>Abner Britton</i>				25a. REC'D BY REGISTRAR <b>JAN 20 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

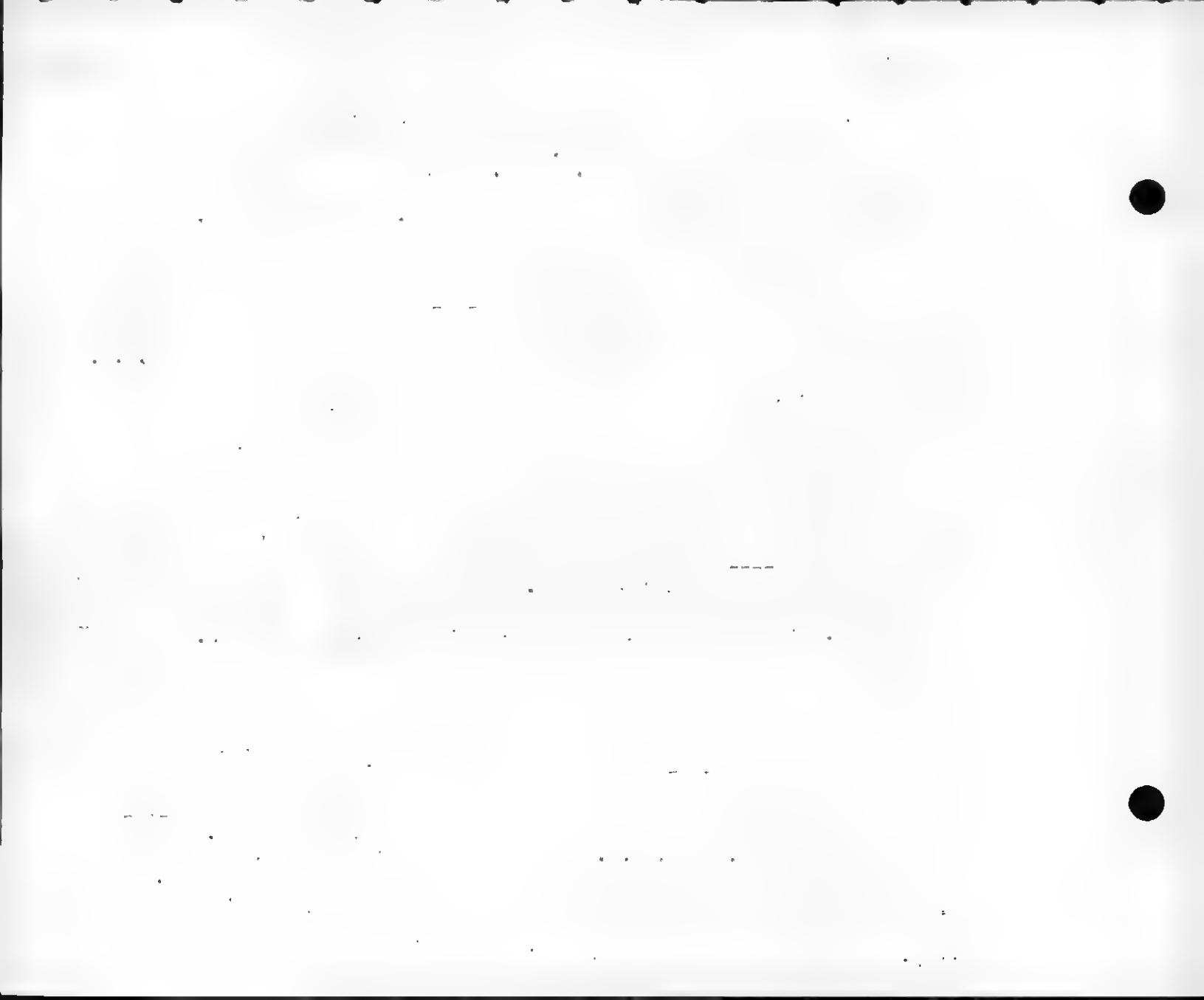
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00583

00573

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Virginia</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Norfolk</b>	
c. LENGTH OF STAY IN 1b <b>10 yrs./2 mos</b>		d. STREET ADDRESS <b>4906 E. Princess Ann Rd.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Springfield State Hospital</b>			
3. NAME OF DECEASED (Type or print) <b>George Edward Turner.</b>		4. DATE OF DEATH Month <b>JAN</b> Day <b>23</b> Year <b>1966</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-25-1908</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stevodore</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SHIPPING</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert Prince Turner</b>		14. MOTHER'S MAIDEN NAME <b>Sally Bryant</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>?</b>	
17. INFORMANT <b>Springfield State Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Confulent Bronchopneumonia.</b> DUE TO (b) <b>Heart failure due to Coronary arteriosclerosis</b> (c) <b>and massive destruction with fibrosis of left ventricle wall.</b> PART II. OTHER SIGNIFICANT CONDICTIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDICTION GIVEN IN PART I (a) <b>CBS assoc. with Alcoholic Intoxication with psychotic reaction.</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>days</b> <b>weeks</b> <b>years</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>11-16-55</b> , 19 <b>55</b> , to <b>1-23-66</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>1-23-66</b> , 19 <b>66</b> , and that death occurred at <b>3:15 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>[Signature]</b>		22b. DATE SIGNED <b>1-23-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Samuel P. Wise, M.D.</b>		22d. ADDRESS <b>Springfield State Hospital Sykesville, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>1-25-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>[Signature]</b>	23d. LOCATION (City, town or county) (State) <b>Sussex Co. N.J.</b>
24. FUNERAL DIRECTOR <b>[Signature]</b>		25. REGISTRAR'S SIGNATURE <b>[Signature]</b>	
25a. REC'D BY REGISTRAR <b>[Signature]</b>		25b. DATE <b>JAN 26 1966</b>	



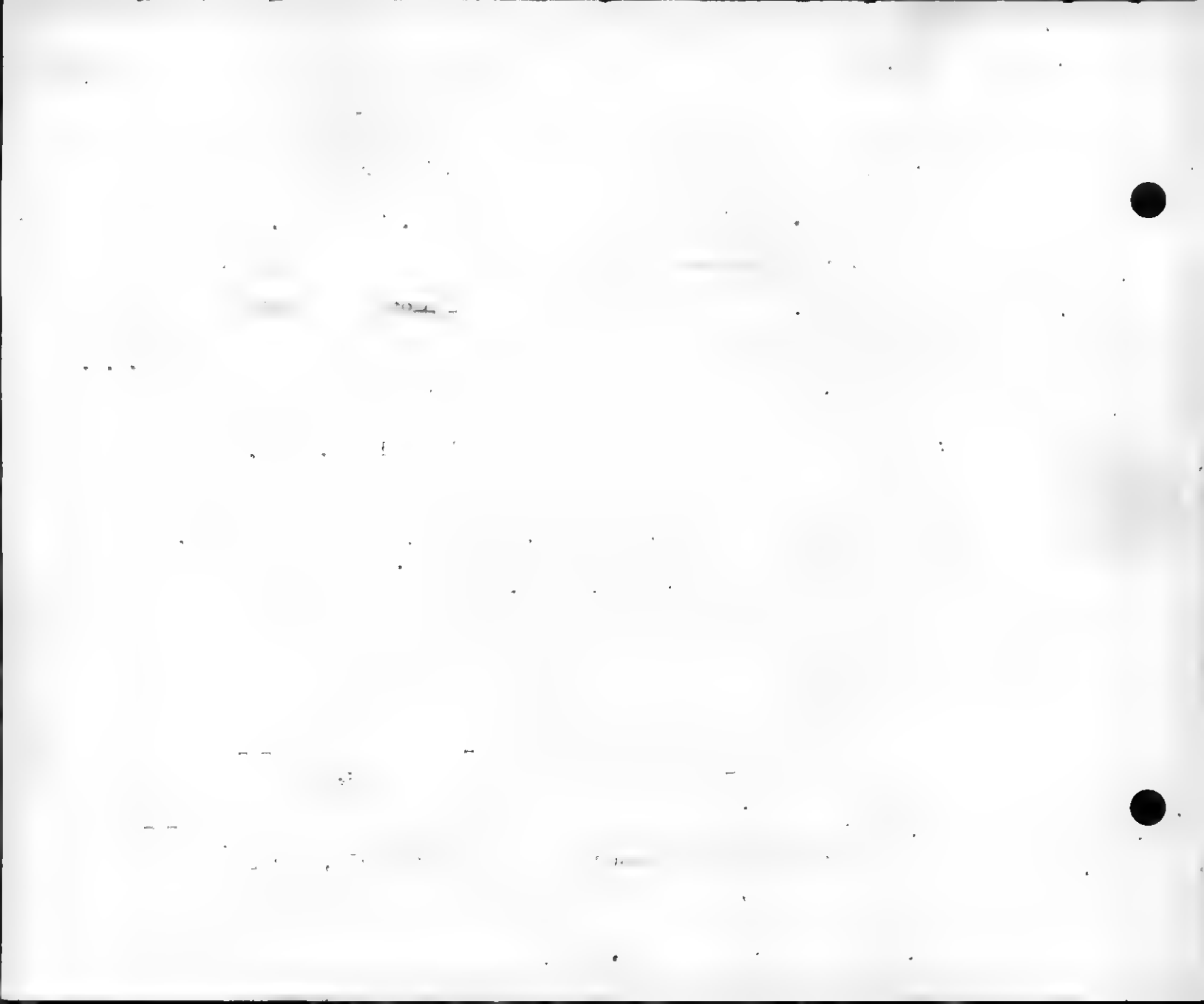


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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00584 CERTIFICATE OF DEATH 00574									
1. PLACE OF DEATH a. COUNTY <b>Carr oll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> c. LENGTH OF STAY IN 1b <b>4 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Springfield St. Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore, City</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>30-4</b> d. STREET ADDRESS <b>2855 W. North Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Sarah Elizabeth Wade</b> First Middle Last					4. DATE OF DEATH <b>January 8 19 66</b> Month Day Year				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-10-93</b>		9. AGE (in years last birthday) <b>72</b> yrs. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Moore</b>					14. MOTHER'S MAIDEN NAME <b>Annie Dorsey</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Springfield St. Hosp. Records</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> <b>4000</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (b) <b>Arteriosclerotic and rheumatic heart disease.</b> DUE TO (c) <b>Bronchopneumonia.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									INTERVAL BETWEEN ONSET AND DEATH <b>weeks</b>  <b>years</b>  <b>days</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>I-4</b> , 19 <b>66</b> to <b>I-8</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>I-8</b> , 19 <b>66</b> , and that death occurred at <b>II:55</b> p.m. from the causes and on the date stated above.									
22a. SIGNATURE <b>Frances Reid Nabors</b>						22b. DATE SIGNED <b>I-8-66</b>			
22c. PHYSICIAN'S NAME (Type) <b>Frances Reid Nabors</b>						22d. ADDRESS <b>Sykesville, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/12/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt Auburn Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore Md</b>			
24. FUNERAL DIRECTOR <b>Adolphus Halstead</b> ADDRESS <b>1206 W North Ave</b>						25a. REC'D BY REGISTRAR <b>JAN 14 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

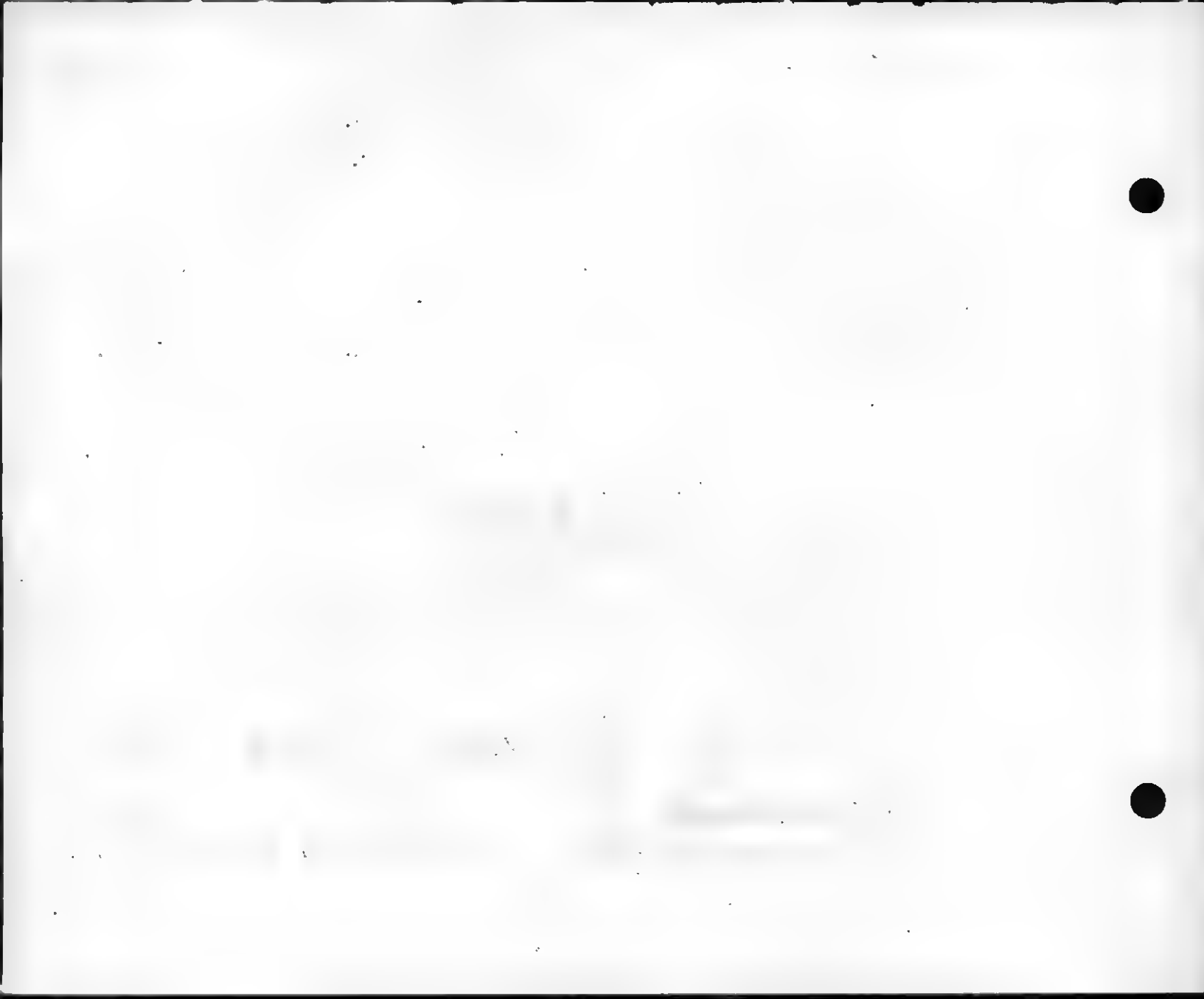
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VR A15 (4)  
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00585											
1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institutions: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Carroll</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Jordan Nursing Home</u>						d. STREET ADDRESS <u>Willis St.</u>					
3. NAME OF DECEASED (Type or print) First <u>Etta</u> Middle <u>E.</u> Last <u>Wagaman</u>						4. DATE OF DEATH Month <u>Jan.</u> Day <u>14</u> Year <u>1966</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/11/1877</u>		9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> IF UNDER 24 HRS. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Cascade Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Samuel Nichols</u>						14. MOTHER'S MAIDEN NAME <u>Elizabeth Royer</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>S. Alan Wagaman,</u>			Address <u>Westminster Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Viral pneumonia and</u> <u>gastroenteritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>  </u> DUE TO (c) <u>  </u>										INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>7/3/65</u> , 19 <u>  </u> , to <u>7/14</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>7/14</u> , 19 <u>66</u> , and that death occurred at <u>1 P.</u> M., from the causes and on the date stated above.											
22a. SIGNATURE <u>Julius Chepko</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7/14/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>Julius Chepko</u>						22d. ADDRESS <u>854 W Green St. Westminster, Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>1/17/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bethel</u>			23d. LOCATION (City, town or county) (State) <u>Lantz #1, Frederick Md.</u>		
24. FUNERAL DIRECTOR <u>Walter J. Grove, Waynesboro Pa</u>						25a. REC'D BY REGISTRAR <u>JAN 17 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. J. J. Judge</u>			

BPD



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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# MARYLAND STATE DEPARTMENT OF HEALTH

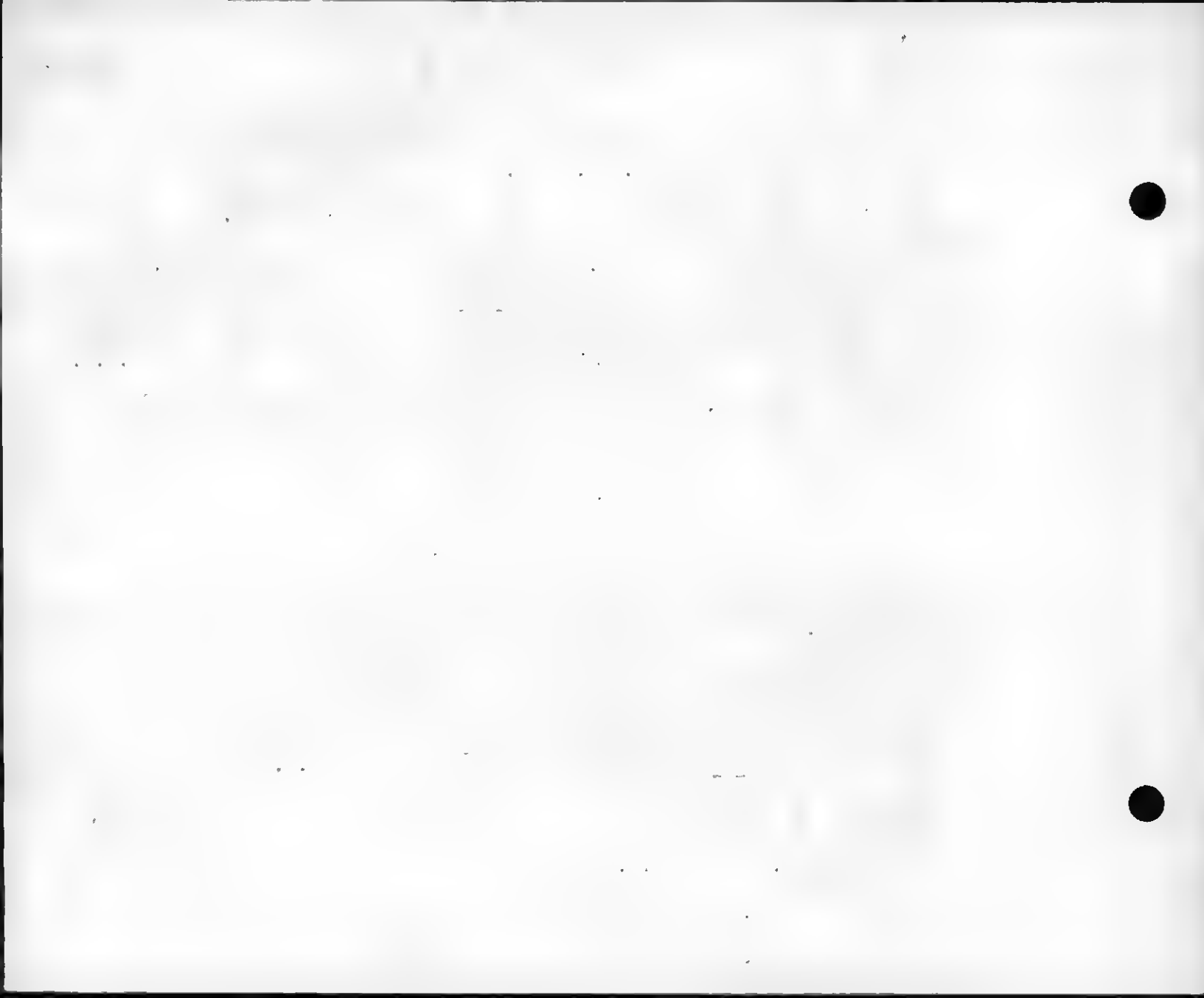
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00586

## CERTIFICATE OF DEATH

00576

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>			c. LENGTH OF STAY IN 1b <b>34yr.6mo.26dys.</b>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Springfield State Hospital</b>			d. STREET ADDRESS <b>1002 Montgomery Rd.</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>ROSE</b> Middle <b>H.</b> Last <b>WELCH</b>			4. DATE OF DEATH Month <b>January</b> Day <b>5</b> Year <b>19 66</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-12-81</b>		9. AGE (in years last birthday) <b>84</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer (Weaver)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Woolen Mill</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>	
13. FATHER'S NAME <b>Unknown Jacob Wm. Welch</b>			14. MOTHER'S MAIDEN NAME <b>Unknown Katherine McFillen</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>		
17. INFORMANT <b>Records, Springfield State Hospital</b>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> 4200 CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST, DUE TO (b) <b>Generalized arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Schizophrenia, paranoid type</b>					INTERVAL BETWEEN ONSET AND DEATH <b>years</b> <b>years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <b>6-9-31</b> , <b>1945</b> , to <b>1-5-66</b> , <b>19</b> , that (I) (we) last saw the deceased alive on <b>1-5-66</b> , <b>19</b> , and that death occurred at <b>4:15 a.m.</b> , from the causes and on the date stated above.					
22a. SIGNATURE <b>Sherrill C. Cheeks</b>			22b. DATE SIGNED <b>1/5/66</b>		
22c. PHYSICIAN'S NAME (Type) <b>Sherrill C. Cheeks, M.D.</b>			22d. ADDRESS <b>Springfield State Hospital Sykesville, Maryland</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>1/7/1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GOODSHEPHERD</b>	
23d. LOCATION (City, town or county) <b>ELLICOTT CITY, MD.</b>		23e. REC'D BY REGISTRAR <b>JAN 13 1966</b>		23f. REGISTRAR'S SIGNATURE <b>J. J. J.</b>	
24. FUNERAL DIRECTOR <b>Easton Funeral Home - Catonsville</b>					

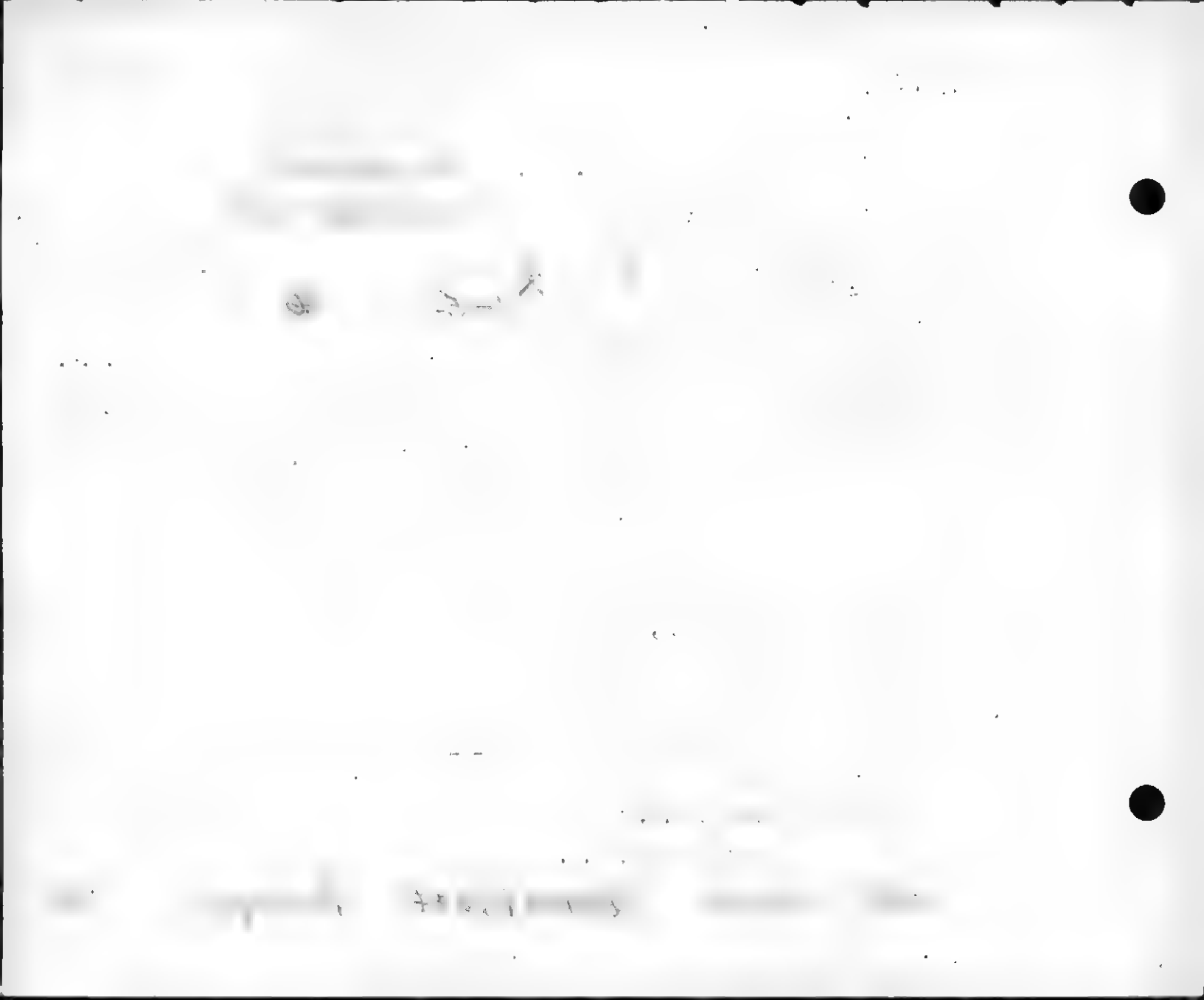


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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00587 CERTIFICATE OF DEATH 00577

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>	
c. LENGTH OF STAY IN 1b <b>36yr. 7mo.</b>		d. STREET ADDRESS <b>13 TUCKER ST.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>E</b> Last <b>White</b>		4. DATE OF DEATH Month <b>Jan</b> Day <b>22</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-5-1900</b>
9. AGE (In years last birthday) <b>66</b> yrs.		10. IF UNDER 1 YEAR: Months <b>6</b> Days <b>1</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles White</b>		14. MOTHER'S MAIDEN NAME <b>Rose Morgan</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address <b>Sykesville Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardio Vascular Disease</b> DUE TO <b>Generalized Arteriosclerosis Advanced</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>—</b> DUE TO (c) <b>—</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Schizophrenic Reaction, Catatonic type</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Years</b> <b>Years</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a.m. <b>19</b> p.m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>6-23-29</b> , 19 <b>19</b> , to <b>1-22-66</b> 19 <b>19</b> , that (I) (we) last saw the deceased alive on <b>1-22-66</b> 19 <b>19</b> , and that death occurred <b>1-30-66</b> from the causes and on the date stated above.	
22a. SIGNATURE <b>Dr. Antonius Glenn</b>		22b. DATE SIGNED <b>1-22-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Antonius Glenn, M.D.</b>		22d. ADDRESS <b>—</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>1-25-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR BLUFF</b>		23d. LOCATION (City, town or county) (State) <b>ANNAPOHIS MD.</b>	
24. FUNERAL DIRECTOR <b>John M. Gay for Sons Annapolis</b>		25a. REC'D BY REGISTRAR <b>1-25-1966</b>	
25b. REGISTRAR'S SIGNATURE <b>John M. Gay</b>		25c. JUDGE <b>—</b>	





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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00588 CERTIFICATE OF DEATH 00578

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>8mos. 23dys.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>1703 Ashburton St.</b>	
3. NAME OF DECEASED (Type or print) First <b>GOALS</b> Middle <b>SAMUEL</b> Last <b>WILSON</b>		4. DATE OF DEATH Month <b>JANUARY</b> Day <b>14</b> Year <b>19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Sep DIVORCED	8. DATE OF BIRTH <b>7-20-1904</b>
9. AGE (In years last birthday) <b>61</b>		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>14</b> Hours <b>19</b> Min. <b>66</b>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Embalmer</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Samuel Wilson</b>	
14. MOTHER'S MAIDEN NAME <b>Rachel Hutton</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service)	
16. SOCIAL SECURITY NO. <b>217-03-3889A</b>		17. INFORMANT <b>Records, Springfield State Hospital</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive bleeding from varices and hepatic coma,</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Larnnec's cirrhosis of the liver.</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH <b>days</b> <b>years</b>	
19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>4-21-65</b> , 19 <b>to 1-14-66</b> , 19 <b>that (I) (we) last saw the deceased alive on 1-14-66</b> , 19 <b>and that death occurred at 3:55 PM</b> , from the causes and on the date stated above.	
22a. SIGNATURE <b>Octavio A. Ruiz</b>		22b. DATE SIGNED <b>1-14-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Octavio A. Ruiz, M. D.</b>		22d. ADDRESS <b>Springfield State Hospital Sykesville, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>1-18-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>MOUNT CALVARY</b>		23d. LOCATION (City, town or county) (State) <b>Arundel Co Md.</b>	
24. FUNERAL DIRECTOR <b>I. L. BROWN + SON</b>		25. REC'D BY REGISTRAR <b>123 W. MONTGOMERY</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. DATE <b>JAN 19 1966</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00589						00579					
1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New Windsor RD#1</u>				c. LENGTH OF STAY IN 1b <u>all his life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New Windsor RD#106-1</u>				d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						d. STREET ADDRESS					
3. NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle <u>EDWIN</u> Last <u>WILSON</u>						4. DATE OF DEATH Month <u>January</u> Day <u>27</u> Year <u>1966</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 29 1907</u>		9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Butcher Helper</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>College dining room</u>		11. BIRTHPLACE (County & State, or foreign country) <u>New Windsor RD. Md. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>John Wilson</u>						14. MOTHER'S MAIDEN NAME <u>Mary Jane Johnson</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>  </u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>213-16-0957</u>		17. INFORMANT <u>Mrs. Walter Smith Jr. New Windsor RD#1</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u> DUE TO <u>  </u>										INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>9/7</u> , 19 <u>65</u> , to <u>1/27</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>1/27</u> , 19 <u>66</u> , and that death occurred at <u>1:30 P.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Julius Chepko</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/28/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>Julius Chepko</u>						22d. ADDRESS <u>854 W. Green St. Westminster Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>1/30/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Western Chapel Cemetery New Windsor RD#1 Md.</u>		23d. LOCATION (City, town or county) (State)			
24. FUNERAL DIRECTOR <u>J. E. Myers Jr. Westminster, Md.</u>						25a. REC'D BY REGISTRAR <u>FEB 1 1966</u>		25b. REGISTRAR'S SIGNATURE <u>  </u>			

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Taneytown</b> c. LENGTH OF STAY IN 1b <b>Rural Taneytown</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>RFD #2</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Taneytown</b> d. STREET ADDRESS <b>RFD #2</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Norman</b> Middle <b>Wilson</b> Last <b>Wood</b>				4. DATE OF DEATH Month <b>January</b> Day <b>26</b> Year <b>19 66</b>							
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 28, 1921</b>		9. AGE (In years last birthday) <b>44</b> yrs.		IF UNDER 1 YEAR Months <b>44</b> Days <b>44</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Rockingham Co., Virginia</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Ellis Leonard Wood</b>						14. MOTHER'S MAIDEN NAME <b>Mary Ann Shifflett</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Ellis L. Wood</b> Address <b>RFD #2 Taneytown, Md.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> 4201 DUE TO (b) <b>Hypertensive Cardio-Vascular Dis.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>Generalized Arteriosclerosis</b>										INTERVAL BETWEEN ONSET AND DEATH <b>Several Days</b> <b>5 yrs</b> <b>5 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Obesity</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour <b>9</b> a.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>June 7, 1965</b> to <b>Jan 22, 1966</b> , that (I) (we) last saw the deceased alive on <b>Jan 22, 1966</b> , and that death occurred at <b>11:30 A.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>E. Ambler Thompson</b> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1/28/66</b>			
22c. PHYSICIAN'S NAME (Type) <b>E. Ambler Thompson, M.D.</b>						22d. ADDRESS <b>49 Frederick Street, Taneytown, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>1/29/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Reformed Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Taneytown Maryland</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>C.O. Fuss &amp; Son</b>						ADDRESS <b>Taneytown, Maryland</b>		25a. REC'D BY REGISTRAR <b>FEB 1 1966</b>		25b. REGISTRAR'S SIGNATURE <b>James Judge</b>	

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